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BASIC HEALTH SERVICES

PHASE II

USAID/AFGHANISTAN

May 1978

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ANNEX A.

Project Authorization and Request for Allotment
of Funds

ANNEX B.

Certification Pursuant to Section 611(c) of the
Foreign Assistance Act of 1961 as Amended

ANNEX C.

Country Checklist

ANNEX D.

Standard Item Checklist

ANNEX E.

Project Checklist

ANNEX F.

Traditional Health Care in the Near East by
Barbara L. K. Pillsbury

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5. PROJECT NUMBER (7 digits) <input type="checkbox"/> 306-0144 <input type="checkbox"/>	6. BUREAU/OFFICE A. SYMBOL NE	B. CODE <input type="checkbox"/> 03 <input type="checkbox"/>	7. PROJECT TITLE (Maximum 40 characters) <input type="checkbox"/> Basic Health Services <input type="checkbox"/>
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TOTALS					

14. SOURCE/ORIGIN OF GOODS AND SERVICES
 000 941 LOCAL OTHER See Project Paper

15. FOR AMENDMENTS, NATURE OF CHANGE PROPOSED
 Phase II will initiate and sustain a basic health care system in the Girishk Region of Afghanistan to test the system's technical feasibility and economic viability. It will also develop management systems at the central Ministry level capable of supporting the regional health care system and then subsequently a national system.

FOR PROPIAS USE ONLY	16. AUTHORIZING OFFICE SYMBOL	17. ACTION DATE MM DD YY	18. ACTION REFERENCE (Optional)	ACTION REFERENCE DATE MM DD YY

PART I. - SUMMARY AND RECOMMENDATIONS

A. Grantee and Implementing Agency

The Grantee will be the Government of Afghanistan. The executing agency for the Government will be the Ministry of Public Health (MOPH) Within that Ministry, General Presidency of Health Services will be responsible for execution of the Phase II project. Below the Kabul level, the Regional Training Center and Basic Health Centers will supervise project execution within their geographic areas of responsibility.

B. The Grant

The financing proposed for Phase II is \$13,984,000. Obligations are proposed as follows:

<u>FY 1978</u>	<u>FY 1979</u>	<u>FY 1980</u>
\$2,800,000	\$5,389,000	\$5,795,000

The allocation of proposed financing for Phase II project is as follows:

Technical Assistance	\$ 5,993,000
Participant Training	1,071,000
Project Commodities	1,372,000
Construction	3,417,000
Contractor Support Costs	1,181,000
Project Local Costs	950,000
	<u>\$13,984,000</u>

C. Program Goal

Improved health status of the rural population.

D. The Project

The Phase II project will introduce a system for basic health care delivery in the Girishk region of Afghanistan and strengthen MOPH management systems. The basic health care system calls for an integrated three-tiered health delivery and technical/managerial support structure. Levels of care include:

- Village Systems. These systems will include 350 Village Health Workers and 650 traditional mid-wives or Dais operating in the Girishk region. They will provide some curative health services but with major

emphasis on preventive health care. Through short training programs, the workers will acquire limited, though critical, medical skills. They will refer patients with certain categories of symptoms to Basic Health Centers for treatment.

- Basic Health Centers. This system will include 25 Centers in the Girishk region staffed by a Doctor, male Nurse, Auxiliary Nurse/Midwife or other female health worker, Sanitarian, Vaccinators, associated technicians and clerks, and in some cases a non-physician manager.

- Provincial Hospitals. There are four provincial hospitals in the Girishk region. They take referrals from the Basic Health Centers as well as operate as BHCs themselves within their own geographic area. This component will be the subject of study during the Phase II project and findings from that may lay the basis for a project amendment.

There are three levels of technical and managerial support:

- Basic Health Centers: the Centers are responsible for supervision of village-level programs and care of referrals from that system.

- Regional Training Centers: currently responsible for training in the regions and supervision of Basic Health Center operations. It is envisioned that these Centers will also become important elements in decentralized management of the basic health delivery system.

- Ministry of Public Health: to support these health complexes and the Phase II test, as well as to lay the base for national replication of a basic health delivery system, the Phase II project will emphasize the improvement and operation of required management and operations support systems: training, personnel, planning, budgeting and accounting, communications and supply and logistics.

E. Project Purpose

The Phase II project purpose is to:

- initiate and sustain a health care system experiment in the Girishk region directed at the major health problems of the region, which will provide preventive, curative and referral services to a majority of the population, and which could constitute a feasible and viable model for national replication.

- develop a management system within the MOPH capable of supporting a regional basic health care delivery system and prepared to launch a national delivery system.

F. Other Donor Assistance

There are a number of other donors, both bilateral and multi-lateral, providing assistance to improve the health status of Afghanistan's rural population. The Phase II project is essentially a Government/USAID proposal, however. For a full discussion of other donor assistance refer to the Mission's Health Sector Assessment.

G. Issues

There are four issues to be resolved prior to authorization of the proposed Grant. All other issues relating to the Phase II project have been integrated into the design.

- authority to negotiate a contract amendment with Management Sciences for Health (Part IV, B.2);
- waiver of the Government 25 percent contribution (Part IV, B.2);
- incorporation of Phase I construction in Phase II funding (Part II, B.3,d); and
- waiver of usual source origin requirements for drug procurement (Part IV, B.5)

H. Statutory Criteria

The Phase II project meets all applicable statutory criteria.

I. Summary of Findings

The technical design of the project is feasible. Cost estimates are firm, and prices are reasonable. Technical, financial, social and economic analyses indicate that the Phase II project will meet its objective and will benefit the rural population of Afghanistan.

J. Recommendation

Phase II project authorization with approval of the following:

- negotiation of the technical assistance contract;
- waiver of the Government's 25% contribution; and
- incorporation of Phase I construction.

PART II: PROJECT BACKGROUND AND DETAILED DESCRIPTION

A. Background Summary

1. Mission Experience

The Agency for International Development initiated a public health program in Afghanistan in 1972. That first program was directed at population control and family planning. It was premised on the development of the Basic Health Center (BHC) as a means of delivering MCH as well as contraceptive and family planning services.

The Ministry of Public Health (MOPH) had recognized the obvious necessity of women health workers to provide health and family planning services and requested AID assistance at the Auxiliary Nurse/Midwife (ANM) School in Kabul. With AID assistance, a new School is now complete and occupied; the faculty is in place and will have completed training by early 1979; and graduates are being assigned to positions in the BHCs.

In 1973, the AID program was expanded, and Management Sciences for Health (MSH) was contracted to provide management services to the MOPH - again to strengthen the MCH/family planning services of the BHC system. The MSH team also undertook basic analyses of the Ministry's management systems. Most of what we know today of the public health system in Afghanistan is attributable to their work. Their early work at upgrading selected BHC operations resulted in an almost three-fold increase in utilization of BHCs. And within that dramatic statistic, it is interesting to note that utilization of the BHCs by women and children reflected an almost four-fold increase.

Based on that early success, the MOPH requested AID to broaden its support in public health to include construction of additional BHCs and testing of alternative village health delivery systems. AID responded to that request and authorized a Phase I Basic Health Services project in 1976 which included not only the construction and testing but a continuation of management advice and support to the ANM School. An evaluation in October 1977 suggested a broader test of the management system and village based delivery systems was warranted. A Health Sector Assessment was completed in January 1978 and a Country Development Strategy Statement (CDSS) submitted in March 1978. The Phase II project is derived from that experience, analysis and close collaborative work done by MOPH and MSH personnel.

2. Mission Assessment

MOPH public health programs have not yet had a significant impact on the majority of rural people. So far, coverage is inadequate and the organization and management of preventive programs is less than desirable. These deficiencies must be remedied for universal quality health care.

The current low level of population coverage is the direct consequence of Afghanistan's dispersed population and the low utilization of existing programs by people with potential access. The latter problem must be of particular concern to the MOPH as it implies resources, particularly scarce trained manpower, are not being used efficiently. It is also significant that an increase in coverage could be achieved at little additional cost. The dispersed nature of Afghanistan's population poses additional problems. Since much of the population lives in small isolated villages the number of BHCs required to reach the majority of the rural population is extremely large and many centers would be below the minimum efficient size even if constructed. A low-cost alternative is provided by the proposed village-level health delivery systems.

As noted above, a large part of the failure of the BHC system stems from the dispersed nature of the population and the inadequacy of transportation facilities. In Afghanistan although some patients come from over 10 km. away, a survey of five BHCs in Parwan province indicated that half of the patients came from between 2 and 6 kilometers. For practical purposes, the BHCs had "catchment areas" of only 6 kilometers. As a consequence, BHC utilization has been limited - even assuming only one visit per patient, with approximately 495,000 visits per year to BHCs, less than 6 percent of the total settled rural population visited a BHC in 1976. The average number of visits to each of the 114 BHCs daily is less than 12. This represents serious underutilization of the services. And if such utilization patterns persist, the completed network of BHCs would receive less than 7 percent of the rural population. A functioning village-based referral system is essential. Management and professional assistance is necessary to enable them to provide the services they are intended but which, for lack of trained staff and materials, they are unable to provide at present. Similarly, they must make major efforts to improve their preventive capacity and particularly outreach beyond the catchment area.

If village-level programs are introduced and implemented, basic health coverage could rise significantly in a relatively short timeframe. As the number of villages is large and comprise so much of the total population, village-level programs are clearly the only viable means of providing widespread health services at low cost. For this

reason, they must expand at a much faster rate than currently envisioned if all Afghans are to have access to health services in a reasonable time period. As noted in the Sector Assessment, however, a comprehensive field test to evaluate the effectiveness of village programs is necessary prior to nationwide implementation.

Improving the quality of health care in a system undergoing constant expansion with free provision of health services must inevitably result in soaring costs. Unless the Government is willing to commit itself to the substantial costs of totally free health services, free health services will necessarily mean limited health services. The population attaches tremendous importance to health care, and, as surveys have shown, spend large amounts on it. To deny people health services for which they are willing to pay, in the name of providing free services, is inconsistent. A fee-for-service system must be considered. There is every indication that most Afghans would prefer a system under which they paid a modest charge but received good treatment than inadequate service provided free. For instance, drugs could be charged at cost to help purchase more drugs and, indeed, to support village-level programs. It is crucial that revenue collected under these programs, particularly drugs, be returned to the MOPH to allow the purchase of future supplies or support of village programs and not be swallowed up in general government revenues.

Hospital care is an important element of any modern public health care delivery system, but in Afghanistan it is overemphasized in relation to other health services. Hospitals are primarily suited to the curative treatment of episodic illness, not the ongoing problems of malnutrition, contaminated water and poor environmental hygiene that face most Afghans. Hospital services are concentrated in urban centers. This makes the distribution of health services under a hospital-oriented system inequitable--in Afghanistan approximately the same number of urban and rural inhabitants have access to health services despite there being some six times as many rural inhabitants. Urban services are undoubtedly of higher quality too, with their more-assured supplies of drugs and manpower. Clearly there is a need to re-structure the system.

If public health in Afghanistan is to improve in the long-run, the principal causes of poor health - environmental disease, malnutrition, etc. will have to be eliminated. The focus of health care must shift from curative urban-oriented hospital care to preventive measures undertaken from within the village on a continuous basis. Reorienting the health program towards preventive services entails expanding health education programs. Implementation of rural health programs is critically dependent upon successful expansion of village-level programs. In conjunction with the BHC staff, village workers must assume leadership roles in health education. They must visit homes and schools to discuss the importance

of proper nutrition particularly for the young, and to explain the vicious circle of poor environmental sanitation, contaminated water, child-spacing and poor health.

The health problems of Afghanistan are serious but basic. They call for a public health system that focuses on widespread adoption of simple low-cost preventive health measures and, as the illnesses arising from such conditions subside, increasingly devotes itself to problems that require genuine curative measures. The former regime took the reverse approach with the consequence that health services are inequitably distributed, largely inappropriate and inefficient. Only recently has an alternative been formulated which can now be tested as a "system" to determine whether it constitutes a feasible and viable model for replication.

3. Mission Strategy

The pattern of illness leading to death in Afghanistan is well recognized. It consists of diarrheal, communicable and respiratory disease. Causes are equally known and rooted in ignorance. They are manifested in poor nutrition, inadequate sanitation and uncontrolled fertility. The situation is compounded by the absence of effective health services. The consequences fall primarily to the vulnerable, the isolated and the poor. In Afghanistan, these are disproportionately women and children. This group must be the focus of any public health program, although an attack on the fundamental causes of illness will benefit all elements of society.

The services of the Ministry of Public Health are largely inappropriate, inefficient, inequitably available and of little standing with a majority of the population. The Ministry is urban centered and curative oriented. With the important exception of the Village Health Worker and Dai programs, the Ministry has failed to take advantage of the indigenous system which already exists at the village level.

While the indigenous system is a patchwork of myth, tradition and ancient Arab practice, and is characterized by general ignorance of modern medicine, it is in every village and is available equitably. It is also affordable, self-sustaining and enjoys the confidence of the people. The CDSS took as a major objective to reorient the national health system to meet the needs of its rural population and relate it where feasible to the indigenous system.

AID, in its Phase I project assisted the Government to develop a system centered in the village and focused on nutrition, sanitation, immunization, health education and MCh/family planning services. The

Mission also assisted the Government to link its public health systems to indigenous systems and to rely, at least partially, on the public for its financing. The Mission believes the health systems in Afghanistan could draw strength from its dual aspect. Finally, we have made it clear that AID would support a national or universal system with broad coverage and not one catering by design or default to select portions of the population.

Current programs in village service delivery suggests the broad outlines of a strategy. Current efforts, while giving cause for encouragement, however, are too limited in scope to give the answers needed for design of a national program. An expanded effort is called for to answer these questions and to develop capacity to support a national program. The following three steps constitute a transitional strategy:

field experimentation. While the overall health delivery system of the country is extremely weak, the directions in which progress is likely have been identified through recent pilot tests. Focus has been on identifying mechanisms independent of the Basic Health Center network, and others which expand each Center's capabilities. Initial results are encouraging, but the question remains whether they are feasible and affordable under normal field conditions. What is required is to test whether, in a specific area, it is possible to recruit and train workers, supply and supervise them, and develop a functional referral system so that a majority of the population begins to receive the benefits.

management systems development. Even the most appropriate service delivery approaches will have little impact unless they can be implemented effectively by the Ministry of Public Health. The range of management problems is well understood, and initial efforts to resolve them have shown possibility for improvement. Our aim is to focus management system support for services that impact on the fundamental causes of morbidity and mortality in the village. The development required is of such magnitude that a greatly expanded effort is required. The issue is purely a practical one: not whether ideal operating efficiency will be attained, but whether the critical constraints can be relaxed to the extent that acceptable levels of service delivery will be achieved. During the field experimentation, USAID support will help strengthen institutional capacity of the Ministry of Public Health. This means improving: manpower planning/

training, logistics, financial planning and budgeting, information systems, evaluation and program planning, management training and personnel management.

The final component of the transitional strategy recognizes that knowing what to do (i.e., field experimentation) and how to do it (i.e., management systems development) are of little benefit without the necessary resources. Field experimentation will contribute in two ways. First, carefully collected and analyzed data can provide information on resource requirements for national implementation. Second, it can demonstrate whether or not financing through fees for drugs is feasible. If the Phase II project is successful, with GOA support AID could support a sector grant as early as 1982 that address the fundamental public health needs of a majority of the population and offers the prospect of nationwide implementation of an appropriate delivery system.

B. Detailed Description

1. Basic Health Services in Afghanistan

Before moving to a description of the proposed Phase II project, it is important to understand the health system model on which the project is based. The term "system" implies that the various parts of the model work together to provide a package of health services. Although each part has identifiable functions and may appear to operate relatively independently of the other parts, the system is not complete without all parts, and underdevelopment of one part affects the efficiency and effectiveness of all other parts.

The basic health care delivery model proposed for Afghanistan is based on MOPH thinking and testing over the past four years. It also reflects the work and recommendations of Management Sciences for Health (MSH). The model constitutes distinct and defined levels of care, distinct and defined levels of technical and/or managerial support and, of course, appropriate linkages between both levels and systems. The complete model includes five levels of care and three levels of technical and/or managerial support:

Levels of Care

Village-level health
delivery

District-level Basic
Health Centers

Provincial-level
Hospitals

Regional-level
Specialty Hospitals

Kabul Comprehensive
Hospitals

Levels of Technical/Managerial Support

District-level Basic Health Centers

Regional-level Training Centers

Ministry of Public Health Central
Ministry operations - Kabul

The Phase II project will focus on a basic health care delivery system which includes the first three levels of care and the three levels of technical and/or managerial support. Responsibility for provincial hospitals is not within the purview of the Basic Health Services Presidency of the Ministry of Public Health and will be the subject of separate analysis during Phase II. Nevertheless that first level of hospital care is considered an integral part of any basic health care delivery system and is reflected in the project concept.

2. The Basic Health Service System

The following section is in summary form. More detailed descriptions and analyses can be found in a variety of Mission, Ministry and MSH documents. These documents are specifically cited where relevant for incorporation in this Project Paper and later evaluation. They are available in Mission records and in the files of NE/TECH.

a. Village-level Health Delivery

See "A proposed Village Health Worker Program", March 23, 1977 by Dr. Rafiq Miazad, Director of Primary Health Care Development, Ministry of Public Health. Published in cooperation with the Management Team, Management Sciences for Health.

A village-based delivery system is the key to serving the rural population. The MOPH realizes that the current network of hospitals and BHCs is inadequate for providing the nation's 14 million rural inhabitants scattered in some 20,000 villages with basic health care.

The Ministry's plan is to provide Village Health Workers and to train traditional midwives, Dais, so that 75 percent of the rural population has reasonable access to the village-level system. The plan is similar to the "barefoot doctor" schemes of other countries. Rural people currently receive health care from indigenous healers or travel long distances to health centers, private doctors or hospitals. In essence, they are outside the public health system.

The Village Health Worker (VHW) and the Dai are trained to offer basic packages of care to their fellow villagers.^{1/} They share certain skills, but carry out complementary activities within the village. For personal health services, the VHW is meant to serve adult men, older boys, and younger children when asked, as well as providing drugs for all villagers. Under the plan, volunteers, chosen by a Village Committee and screened for suitability by the MOPH would undergo intensive training by teams from the Regional Training Centers. They would be instructed in fundamental hygiene and nutrition, diagnosis and treatment of simple illnesses and health education techniques. Specifically, the VHW is trained to recognize and treat common gastrointestinal and respiratory illnesses, eye and skin diseases, anemia and malnutrition. His community activities will include advice on environmental health problems such as water, waste disposal, cleanliness of the home and personal hygiene. The VHW is taught to prescribe selected oral drugs, and he derives his income from the sale of these drugs which he buys prepackaged at the BHC. The VHW will be attached to the nearest BHC, from which they will draw supplies and to which they will refer more serious cases.

The Dai offers personal health services to women and young children. Her training seeks to improve her midwifery skills so that she can conduct a normal delivery safely. She is taught to recognize high risk pregnancies and refer these to the BHC or provincial hospital. She is trained in preventive/educative care for pregnancy, labor, delivery and post-birth periods. The Dai is also taught to recognize common health problems of children and is able to differentiate the normal child from the mildly sick and seriously sick. The community activities of the Dai involve counselling of women on all of their health problems including family planning. She derives her income from delivering babies, and in some cases, from her child care services.

Village-level health services are limited to common problems of the village family. The quality is less than would be given by a BHC worker. The care is simple but extremely important, as the village-based workers are the key personal link to the village family. As fellow villagers, they can be effective health educators of village people.

^{1/} See Technical Analysis for issues related to the village-worker system.

Indeed the success of the village-level system is largely contingent upon the degree to which it can be integrated into the mainstream of everyday Afghan village life and the village social structure. The VHW and Dai are recruited and proximally supervised by a Village Committee. Technical supervision is from the Basic Health Center. It is planned that one BHC worker, probably the sanitarian, will be the official link between the village and BHC systems. Initial training and continuing education activities will be the responsibility of the Regional Training Center.

It is important to note that the village-based delivery system, (albeit semi-controlled and supervised), is a private one in which people pay for services rendered. The Government of Afghanistan will provide the training, supervision and logistic support. Experiments at Home Visiting or Community Based Distribution for family planning materials would place the Dai in a quasi-public status which would be at least partially state supported.

b. District-level Basic Health Centers

See "Basic Health Center System, Plan of Operations", August 1975. Published by the Basic Health Services Presidency, Ministry of Public Health. See also "Basic Health Centers Manual", February 1978. Published by the Ministry of Public Health in cooperation with the Management Team, Management Sciences for Health. See also "Training Strategies for the Basic Health Center Component of Rural Health Services", April 1975. Published by the Management Team, Management Sciences for Health.

In the proposed basic health services system, the BHC is the cornerstone on which village-based programs are built. The BHC is a multi-purpose health institution, providing both preventive and curative services. It will also be the management unit for a geographic area which will include about 15 VHWs and 25 trained Dais in surrounding villages. These villages may extend more than 40 kilometers from the BHC. This entire geographic area becomes the "management area" of the BHC. All village-based workers in the management area will receive supervision and logistic support from the BHC. Trained workers from the BHC will provide these management and technical support services.

The BHC offers facility-based curative services to those within a 10 kilometer radius - its "catchment area". It is also the referral unit for its management area. Trained curative care workers at the BHC will include a physician, a male nurse and a trained female worker (auxiliary nurse midwife or other trained female). It will offer a package of curative care services and education for the patients about their illnesses. Treatment services will include nutrition rehabilitation,

oral rehydration, minor surgery, obstetrical services and provision of basic drugs and contraceptive commodities. More serious cases are referred to the provincial hospital.

In addition to the professional medical personnel noted above, the BHC staff includes a sanitarian and two vaccinators. As the community activities become better defined, other new categories of workers may be needed. The entire BHC staff will regularly offer facility-based preventive health education and family planning services. People coming to the BHC receive such preventive/educative services as well-child care, immunizations, maternity care, tuberculosis testing and malaria testing. Community health topics will be taught for the surrounding community. All BHC workers will be involved in these activities and will be trained in how to move effectively health education programs for village people.

The BHC plans to offer outreach services within its catchment area. The area will expand over time as financial resources increase and delivery mechanisms are identified and tested. Planned outreach services include, as a minimum, the following: vaccination and immunization of children against smallpox, tuberculosis, diphtheria, whooping cough, and tetanus; inspections of public eating and sleeping facilities; school health education programs, and community health education programs. This minimum program will be implemented by the BHC sanitarian, vaccinators and female health worker.

The BHC also has technical support functions in the proposed basic health services system. It will continue to have limited routine laboratory services for anemias, parasites, urinary problems, malaria, tuberculosis and other common conditions. A vastly expanded function of the BHC will be provision of technical support for health education/communications activities. The sanitarian, or other BHC workers, will be trained for this role and will provide technical advice to other BHC workers and to village-based workers on the use of health education materials and organization of group meetings.

The BHC also has management support functions in the proposed basic health services system. The manager of the BHC will be responsible for all health related activities in his management area. His work will include planning, implementing and evaluating all facility-based and outreach preventive and educative programs of the BHC and supervising all Home Visiting and Community Based Delivery system workers. His sanitarian will supervise the activities of village-level workers. The manager's job will also include monitoring and reporting on work quality and work loads of his staff and village-workers. He will schedule all programmatic activities, direct the ordering of drugs and health commodities, maintain financial accountability and plan personnel needs.

Finally, he will monitor and report on disease conditions in his management area.

Various international health research studies have found that the physician, the traditional clinic manager, is neither interested nor skilled in managerial tasks. Experience provides little reason to believe Afghanistan is different. In the Phase II project, experimental trials of using non-physician managers will be implemented and evaluated.

It must be mentioned that management control of the village-based system is not complete, since the VHW and Dai are not government employees. The VHW could get drugs from other sources. The Dai has been practicing in the villages for centuries. The MOPH will attempt to exert management control through supervision from the BHC and through continuing education from the Regional Training Center. Consideration should be given to licensing of these workers, although trials are not anticipated in the Phase II project.

c. Provincial-level Hospitals

See "Hospital Programme - 7 Year Plan: Project/ Programme Document", January 1977. Published by the Planning Department, Ministry of Public Health.

The first level of hospital care for a majority of the population is provided at the provincial hospitals. The provincial hospitals provide more sophisticated and specialized services than the BHC. It is the principal referral point for patients that cannot be adequately served by the BHC. It is an essential element of any basic health services system. The recommended staffing pattern would include a general surgeon, an obstetrician/gynecologist (female if possible), a pediatrician, general family doctors, nurses and auxiliary nurses. At bottom, the hospital must have an adequate general surgical capacity. The polyclinic of the hospital is staffed much like the Basic Health Center, and its functions are similar to the facility-based services of a BHC. The provincial hospital should have the appropriate staff to provide an outreach program, similar to that provided by a BHC in its catchment area. It should also provide technical and managerial support to village-based workers situated in villages around the provincial capital as would a BHC. Technical support functions include laboratory and X-ray services, in addition to the technical support functions also provided by BHCs. The laboratory will offer more specialized services than the BHC can offer.

Management support functions are not clearly defined. Currently the provincial hospitals are responsible for the management

support of all BHCs in a province. The Provincial Health Officer (PHO) has responsibility for checking BHC personnel attendance, investigation of complaints, overseeing BHC submission of reports, liaison with the Provincial Governor and other Government offices and technical supervision of the health activities of the BHC. In fact, that latter responsibility has been exercised by the Basic Health Services Presidency of the MOPH. It is intended to test placement of supervisory responsibility with the Regional Training Center in the Phase II project.^{1/}

While the provincial hospital system is within the framework of the Phase II project, a design is not yet complete. In the first project year, an examination of organization and management of the provincial hospitals will be undertaken, and a Phase II project amendment may be recommended subsequently.

d. Regional-level Training Centers

See "Preliminary Proposal for Regional Training Centers, Ministry of Public Health", June 1975; and "Proposal for Girishk Regional Training/Health Center", March 1977. Published by The Management Team, Management Sciences for Health.

The Regional Training Center (RTC) is a relatively new concept within the Basic Health Services system. The first Center is complete and functioning in Girishk. Five other Centers are planned. At the moment, the Center is charged with initial recruitment and training of village-level health workers, continuing education for village-level workers, pre-assignment training for BHC personnel, continuing education and supervision of BHC personnel and specialized training in public health education for BHC sanitarians and vaccinators. To that end, both mobile and fixed training teams are assigned to the Centers and are responsible for training and continuing education functions.

It is contemplated that the Center will also take on management support functions currently assigned to the provincial hospitals but currently exercised by the Basic Health Services Presidency of the MOPH. In this regard, the Regional Training Center in Girishk will assume responsibility for the organization, management, supervision and supply of the village-level health delivery and district-level Basic Health Center systems within its jurisdiction. That component of responsibility will be tested during the Phase II project. Two additional elements proposed for the Centers are not included within the test: health program planning and disease surveillance. Those two assignments will be tested later if initial operations prove successful. Most RTCs will also have an associated BHC facility and in some cases small hospital.

^{1/} This issue is discussed in the Technical Analysis Section below.

e. Ministry of Public Health - Kabul

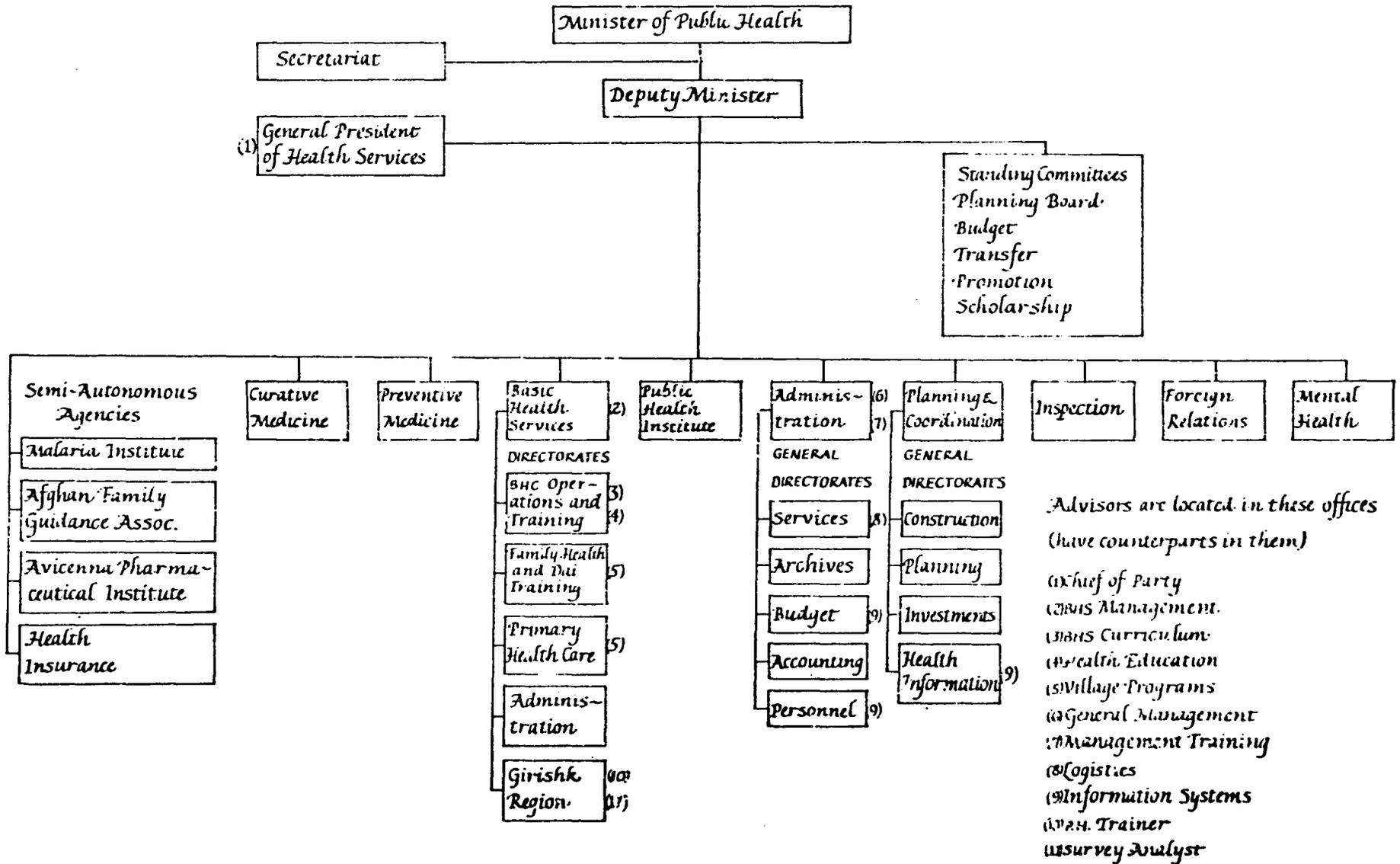
See, inter-alia, "Management Support for Rural and Family Health Services", March 1975. Published by the Management Team, Management Sciences for Health.

The Basic Health Services Presidency is the principal focus of the MOPH rural health effort. In examining the management of Basic Health Services in Afghanistan, a first look at the system of civil administration is necessary. The system is based on the procedures and regulations prescribed in the National Civil Service Law. All civil servants, whether in the central ministry or in provincial operations operate within identical systems of recruitment, grading and remuneration. Many of the problems of morale, salary and effectiveness relate to under-developed personnel practices. The present system does not provide a framework for efficient management. Time and expertise has already been devoted to these matters with improvements in the situation during Phase I. National implementation, however, requires further improvement. This does not mean a radical change in Government policies and procedures, but it does mean that selected key managerial systems must be strengthened and routinized. Examples are cited below.

The system of personnel management has evolved with very little attention to the objectives of basic health administration. Recruitment, transfers, promotions and training to a large extent are not based on merit. However, no evaluation system based on merit is available for decision makers.

Another basic gap in the system is the inadequate classification of positions or definition of functions. In the absence of a classification system, there is no information available as to the nature and responsibility of the various positions or of the qualifications required. The positions of Ministry personnel and contract employees are identified only by their organizational unit or department and the ranks attributed to them. Consequently, assignments of officials are often made arbitrarily without any consultation with either the employee or his supervisor. Moreover, managers frequently have ill-defined ideas about staffing levels and patterns. Another problem is that the purpose or function of the various organizational units themselves has not been adequately defined and consequently the structure of the organization is not sufficiently related to the functions to be performed. A very important weakness that is clearly related to the absence of definition is the lack of responsibility for performance. Because functions are not clearly defined and organizational responsibility for their performance is not clearly assigned, individual officials are not held responsible for accomplishment or failure in specific work areas.

Organization Chart For Ministry of Public Health



Complicated and cumbersome decision making procedures have led to significant bottlenecks in public administration. The lack of delegation of authority or responsibility means that even the most minor decisions and petty administrative details must come before the top levels of management. One effect of this excessive concentration of decision-making in the hands of a few selected senior officials is to discourage initiative. Another effect is to over-burden the top levels of the MOPH with work. Every administrator at the upper level is faced with large numbers of documents requiring his signature. Most documents are signed repeatedly by many officials resulting in lengthy delays in accomplishing the simplest act. This is again a way of avoiding individual responsibility, while at the same time, limiting the effective use of the decision-making capabilities of the junior staff at the Ministry.

A second major category of management deficiency is procurement and supply. Although an elementary materials management system does exist, procedures are so complicated that they create serious bottlenecks in the management of basic health programs and projects. The supply management system including procurement, warehousing, issuing of property records, etc. is based upon the fear of loss through theft or misuse. The system for drugs is a typical example.

The more heavily utilized BHCs find their annual share of drugs insufficient for more than six months operations; in some cases more than 70 percent of all patients must be referred to pharmacies. Of course, if pharmacies are convenient this presents little problem, except costs, but in most cases they are not. Unfortunately the prescriptions are often inappropriate and dosages, therefore, ineffective. Under these circumstances, many of those who are ill do not bother visiting BHCs. Proposals have been made to rationalize the drug distribution system; they must be implemented. The first step involves reorganizing the warehouse, logistics and information system to ensure adequate supplies of drugs when and where they are needed. A second equally important aspect involves rationalizing the drug stocks themselves. Surveys conducted at BHCs have indicated that the 10 most common diagnoses accounted for 57 percent of all diagnoses and the 25 most common accounted for 85 percent. The standard drug issue contains 81 items, some of which are outdated and others little used. A revised list of 40 drugs has been found capable of treating 90-95 percent of all patients who visit BHCs. A full complement of staff and adequate drugs tripled BHC visits to over 26,000 per year in the Parwan pilot project. If the utilization can be increased in other BHCs to the same extent, the envisioned 193 BHC network could reach 3.9 million or about 29 percent of the rural population by 1982/83. With the program reaching this number of people, if MOPH wishes to keep drug costs down and still be able to provide adequate service to all patients, there will

have to be at least a small change for drugs unless the BHS receives vastly increased budgets.

The performance of health sector management in Afghanistan is not simply related to the improvement of the personnel system or materials management regulations and procedures. Improvement in information systems is also a prerequisite for better management of the sector. The state of financial management for example, is such that the opportunities for improvement appear to be limitless. As resource limitations become increasingly critical these financial and budget procedures will become still more important. More effort has to be focused on the various components of the financial system, i.e., accounting, budgeting and revenue collection. The MOPH's ability to manage a basic health service system is closely related to a significant improvement in the ability to account for and report income and expenditure, and to budget its scarce resources. Similarly, improvements in the collection and utilization of health status statistics is absolutely necessary.

3. Logical Framework Narrative

a. Program Goal

Women and children bear a disproportionate share of the health problems in Afghanistan. The Mission Health Sector Analysis points out that 60 percent of the deaths in Afghanistan occur in the 20 percent of the population that is under five years of age. Yet it is this same group that has been systematically excluded from public health services. Moreover, they live predominantly in rural areas, where the previous Government has been unable to provide even minimal levels of health care. This group must be the focus of any public health program, and it is one of our hypotheses that improvements in their health status will reflect improvements in the health status of the population at large. It is not expected that health services to the adult male population will be adversely affected by this project, but, in fact, will similarly improve.

The program goal, outlined in the Mission CDSS, is improved health status of the rural population. This can be accomplished by achieving a favorable change in the natural course of disease through prevention, early detection and treatment. Measuring changes in the course of disease in a population is difficult because most of the changes do not have a rapid aggregate impact and because it is difficult to attribute favorable changes to the health program itself (i.e., health status changes are also sensitive to changes in income among other things). Proxy indicators must be selected to reflect the impact of health care programs, although they cannot be expected to change significantly by the end of the Phase II project. The measures of goal achievement are outlined at Part II, B.4. below.

A Baseline Survey will be funded as part of the Phase II project. The initial survey will be conducted during the first six months of the project and will be repeated in 1981. It will measure goal achievement in terms of the indicators included herein as well as more general indicators of the health status of the population at large. Although the funding is not included as a part of the Phase II project, it is recommended that the Survey be repeated again in 1985. If the Mission moves forward with a Health Sector Grant, funding could be included as part of that later project.

The key assumption is that the Government of Afghanistan adopts and supports a national health care system in accord with the early statements of the new Minister of Health.

b. Project Purpose

Our hypothesis is that a well-functioning basic health care delivery system is a sufficient condition to the improvement in health status of the rural population. From that hypothesis we have defined two purposes for the project:

- to initiate and sustain a basic health care system in a region directed at the major health problems of the region, which will provide preventive, curative and referral services to a majority of the rural population, and which could constitute a feasible and viable model for national replication.
- to develop a management system within the MOPH capable of supporting a regional basic health care delivery system and then subsequently launching a national basic health care delivery system.

i) Girishk Experiment

It is the purpose of the Phase II project to test the proposed basic health care system in a region. During the Phase I project, elements of the proposed system were tested but not within a systems context. During Phase II, an integrated basic health care system experiment will be initiated in the Girishk region of Afghanistan a region covering almost 25 percent of the land area of the country and including almost 15 percent of its population. It includes the provinces of Nimroz, Farah, Helmand and Kandahar. The region already has a functioning Regional Training Center, and 25 BHCs will be complete within a year. There are also four provincial hospitals operating within the region. In that sense the infrastructure is essentially complete. Girishk includes Helmand Province where substantial survey work has

already been completed during AID's 20-year involvement in the Valley. That data will be invaluable to the Baseline Survey.

The Girishk Experiment component of the project purpose consists of three elements: a functioning basic health care system, one which is directed at major health problems and one which is directed at the majority of the rural population. Each of these elements is discussed below.

A Functioning Basic Health Care System. The regional program is in the nature of a test; i.e., whether, in Girishk, it is possible to recruit and train workers, supply and supervise them and then develop a functional referral system so that a majority of the population begins to receive the benefits. The experiment will focus on the three basic levels of care and two levels of technical/managerial support.

With regard to village-level health delivery, the Phase II project will test whether:

- sufficient village health workers can be recruited and trained;
- dai skills can be upgraded;
- village health workers and dais can provide a relevant and effective service;
- a BHC worker can effectively supervise village health workers;
- continuing education programs for village health workers can be organized and regularly scheduled;
- referrals from the village to BHC will constitute an effective link in a basic health service chain; and
- a village-based delivery system can be initiated and sustained on a regional basis.

With regard to district-level Basic Health Centers, the Phase II project will test whether:

- the BHC can provide effective curative care to those within its catchment area and to those referred from its management area;
- the BHC can support Home Visiting and Community Based Distribution programs within its catchment area;
- referrals from the BHC to provincial hospital will constitute an effective link in a basic health service chain;

- the BHC can recruit and effectively supervise and support village health workers
- the BHC can support an effective facility based preventive program within its catchment area and find ways to extend that area;
- the BHC can initiate and sustain community based preventive programs within its management area;
- non-physician managers are an effective management alternative for BHC operations;
- the BHC can maintain information and logistic systems; and
- the BHC can be maintained and supported on a regional basis.

While agreed that the provincial hospitals are an essential ingredient to basic health services, the Phase I project did not address their organization or management. This was partly attributable to the fact that provincial hospitals are not part of the Basic Health Services Presidency of the MOPH. It is proposed, during Phase II, to undertake in the first project year a short-term examination of the provincial hospitals organization and management and to formulate an appropriate test and assistance package in Girishk by amendment during Year I of the proposed Phase II project.

With regard to the Regional Training Centers, the Phase II project will test whether:

- the RTC can train village-level health workers;
- the RTC can mount and sustain a program of retraining and continuing education for village-level health workers;
- the RTC can establish a regularly scheduled program of pre-assignment training for BHC personnel;
- the RTC can mount and sustain a supervisory/continuing education program for BHC operations and personnel;
- the RTC can maintain administrative control over BHC operations and supply of equipment and commodities for the BHCs; and
- the RTC can develop logistic and information systems and constitute an effective link with Central Ministry operations.

The measurement of demand for basic health services, or inclusion of a target for basic health service system usage, has been intentionally excluded. Within the described system, there are factors which will tend to both increase and decrease demand, and to premise project success or targeted demand in such circumstances is not warranted. Further, it is the fundamental objective of any health project to decrease curative demand, and there are no measures of preventive demand. The measures of goal achievement will indicate whether one is or is not having an impact on health status.

A System Directed at Major Health Problems. The Health Sector Assessment outlined the major health problems of the rural population of Afghanistan and showed that they fall disproportionately to women and children. The Phase II project will include several new elements directed specifically at the target group.

The first element will be the establishment of MCH/Nutrition and Oral Rehydration Clinics in all BHCs in Girishk. This is the key element in facility-based prevention. If successful, AID would consider a major project directed to MCH/family planning training as outlined in the recent CDSS.

During the amended project period, extensive testing of a Home Visiting Program (HVP) will also occur. The HVP is directed at training of village women who conduct periodic home visits within the BHC catchment area. Most of the workers will be recruited from the more capable, but non-literate, graduates of the Dai Basic Training Course. Village girls who are sixth or eighth grade graduates are also another source for recruitment in some areas. Using forms designed for non-literate workers, the home visitors will check families for cases of diarrhea, chronic cough (suggestive of tuberculosis), eye inflammation (suggestive of trachoma), malnutrition in children and high risk pregnancy. They will also record information on contraceptive status, births and deaths. They will refer abnormal cases to the BHC. Working with the BHC sanitarian as supervisor, the home visitors will then follow-up abnormal cases on specific schedules every two weeks for malnourished children, every month for tuberculosis, every two months for trachoma, etc., at which time they will do further surveillance and health education. Appropriate BHC workers may also be used for follow-up of problem families. The wolewsal (district officer) should also be involved where community health is threatened. This program is experimental. Results will be carefully followed because early detection of high risk cases by village-based workers is, along with immunization and safe water, the best known approach to reducing child and maternal mortality and morbidity. The use of villagers themselves in case detection, follow-up and educational processes maximizes the chances for behavioral change to occur by involving the village in solving its own health problems.

During the amended project period, extensive testing of a Community Based Distribution Program (CBD) will also occur. CBD is also based on trained village women who conduct home visits. The difference between this and the regular Dai and HVP is that in this instance the village-level worker will also carry commodities, particularly contraceptives. The experiment is important because the Government has yet to allow women to carry or dispense either contraceptive commodities or even simple items like vitamins. The experiment will also facilitate field testing of acceptors and continuous users. In this sense, it is an important research component to family planning in Afghanistan. If successful, expanded efforts at the low-cost delivery of contraceptives and selected health supplies would be tried in the follow-on Sector Grant.

A System Directed at the Majority. A major element of the test, of course, is whether the proposed basic health care system can be made available to a majority of the rural population. While costs are a major issue and financing modes need to be carefully examined, the experiment will focus on establishing Village Health Workers and Dais in villages constituting 75 percent of the rural population of the region. If successful, and if the system can be operationally sustained, AID would address the more fundamental national issue of financial viability in the proposed Sector Grant.

The System as a Model. The experiment in Girishk will only have meaning beyond its direct benefits to the rural population of that region to the extent it can constitute a feasible and viable model for national replication. The description of the system should not be construed as a definitive one. Since the evidence that we now have is based on scattered and non-systematic experiments, the Work and Evaluation Plans will make provision for periodic review and revision where warranted. The Phase II project contemplates baseline surveys in 1979, 1981 and 1983. It also carries financing for independent evaluation, not of contractor performance, but of the health system model. The Evaluation Team would be separate from the Management Team but would work with them on establishing baseline parameters and the project workplan to be submitted for AID and MOPH approval within three months of contractor mobilization.

ii) Central Ministry Systems Development

Any basic health care system requires strong management support from the center to link the various levels of health care together into a total system. Integrated planning, policy guidance, regulations, finance, personnel, material resources, training, supervision and information processing are all essential ingredients for a health care delivery system. Management problems which inhibit the delivery of health delivery services were identified in the Health Sector Assessment.

The Girishk Experiment will provide data on the operations of the proposed basic health care delivery system at the three primary levels of health care, including data on the managerial and technical systems that support and link the three levels. However, for nationwide implementation of the proposed basic health care delivery system, the national infrastructure on which it will be based and dependent must be strengthened. This infrastructure is composed, primarily, of two separate, but overlapping systems: the national systems of BHCs and provincial hospitals together with the technical and managerial functions provided by the Presidencies of Basic Health Services and Curative Medicine; and the Ministry of Public Health management support functions which are provided primarily by the Presidencies of Administration, and Planning and Coordination.

Basic Health Service Systems. The Management unit for MOPH basic health service operations is its Basic Health Service Presidency. This unit manages the village-level health delivery, Basic Health Center and Regional Training Center systems. It is not responsible for hospitals or the support functions of the MOPH. Hospitals are the responsibility of Curative Medicine, and support falls primarily to the Presidency of Administration.

There are two operational levels within the Basic Health Services Presidency: program and administration. Program responsibilities include planning, training and supervision for regional operations. At this point, their major preoccupation is with curriculum development and the scheduling of training teams. Curricula must be developed for all training programs. While there have been initial experiments with village-level programs and supervision for the BHCs, little or no work has been completed in the areas of continuing education at either the village district level or in the area of public health. Both will be emphasized during the Phase II project.

While the proposed basic health care system will be tested in Girishk, it is obvious that central Ministry systems cannot be geared to the operations of a single region. Work will continue in other provinces, and the schedule for opening three additional Regional Testing Centers will be maintained. Experience in other parts of the country will constitute an important referral or verification point for test results in Girishk. To that extent it fits within the purposes of the Phase II project and will be supported. The time devoted to this work will be defined in the initial contractor workplan. The level of support for work outside Girishk is discussed in the Inputs section below and again in the Technical Analysis section of the Project Paper. While the MOPH may also seek to test additional alternate health delivery systems during the Phase II project period, it is not a purpose of the AID financed project and funding for such additional testing is not made available hereunder.

Administrative responsibilities of the Basic Health Services Presidency are paralleled by central Ministry systems and are defined principally by logistic and information systems. Project assistance at the central Ministry level will seek to strengthen and routinize those management systems as well as relate them to the responsibilities and operations of the Basic Health Services Presidency. Again the test will be in the delivery of basic health services in the regions. For purposes of this project, the Girishk experiment will be determinative. For purposes of national replication, it will be necessary that central Ministry systems have demonstrated a capacity for launching a national basic health care system. The contractor's workplan and project evaluation plan should take this measure into account in defining performance targets.

Logistic Systems. The MOPH, with assistance provided under the Phase I Project, is presently designing a coordinated logistics system which embraces the Ministry's principal logistic services including purchasing, storage and transportation. The key element of this system is information management which will assure that all pertinent data is channeled to a central logistics office. A series of schedules for procuring, storing and delivering various types of medical supplies is also being developed. Another Phase I project activity to be continued into Phase II is the revision of the Warehouse Manual. It is anticipated that resulting improvements at the warehouse will substantially decrease the average time from initial requisition of supplies to their final delivery at BHCs and provincial hospitals. These are the fundamental elements of this component of the Phase II project. They will be embodied in the MOPH logistics manual now under preparation and will be tested as a fundamental support system for national replication of a basic health care system.

The scope of the coordinated logistics system will be directed to provision of medical and contraceptive supplies for the Presidencies of Basic Health Services and Curative Medicine. These presidencies deliver most of Afghanistan's health services through a network of 121 BHCs and 45 hospitals. Between them they account for 80 percent of the Ministry's regular budget of foreign purchases.

A major factor in underutilization of existing BHCs, and probably also of provincial hospitals, is shortages of drugs and supplies. Recent experience has shown that when this constraint is removed, BHC utilization increases by a factor of two or three. Significant logistic issues include the procurement of drugs, particularly generics to realize the substantial budgetary saving possible, and innovations such as in unit-of-treatment packaging, a critical component for local financing of drug purchases. Lack of adequate supply and resupply of drugs and supplies at BHCs and provincial hospitals not only decreases user confidence, but destroys staff morale through their inability to carry out the treatments

in which they have been trained. One objective measure of this Phase II project purpose is to increase the percentage of drugs on the standard drug list that are on-hand at BHCs and provincial hospitals.

Drug Packaging and Distribution. The Health Sector Assessment identifies finance as perhaps the major problem for rational elaboration of health programs in Afghanistan. However, it is pointed out that only small increases are even potentially available from Government sources. For example, in 1977 and in 1978, while Ministry of Public Health budget increases were over 12 percent annually, general Government revenues increased at less than 10 percent.

This situation requires that additional sources of financial resources be identified. A recent analysis of individual expenditure on health care estimated, based on village surveys in three provinces, that perhaps as much as Afs. 2 billion (compared to a total MOPH budget of 1 billion) is being spent in the private health sector annually. These expenditures include fees to traditional healers, transportation to BHCs and drug costs, with drugs consuming 37 percent of the private expenditure. Drugs are sold primarily through private pharmacies, although there are a few government pharmacies. This suggests that one source of additional revenue for health might be through the sale of drugs in the village, Basic Health Centers and at provincial hospitals. The system currently provides Afs. 40 to 50 million (\$1 million) worth of drugs and contraceptives to patients free of cost each year. Other means of generating revenue, such as fee-for-service or a health insurance program, are not currently feasible although it would be our intent to pursue the issue with the Government throughout the Phase II project period.

One consequence of the shortage of drugs is that doctors and other health personnel prescribe less than the recommended course of treatment, so that they can "treat" more patients. In many cases these reduced prescriptions result in little or no therapeutic effect from the drugs and a consequent wasting of the limited supply available. It is partly for this reason that this Phase II project will test "course of treatment" packaging. In addition, this type of packaging will make accounting and inventory much simpler.

Another factor supporting the desirability and feasibility of the plan is the fact that the Government has its own pharmaceutical importer and factory for generic drugs, the Avicina Pharmaceutical Institute (API). API is semi-autonomous institution that obtains its operational revenue from drug sales. It has responsibility for approving the import of all drugs and licensing of private pharmacies. A major aim of the Government is to introduce cost savings to both itself and the public through a planned shift to the use of generic drugs, instead of brand-name drugs.

Manpower Planning. There is a need for better manpower forecasting, job analysis and training program planning within the MOPH. MSH predicts a surplus of doctors, an extreme shortage of nursing personnel and sanitarians and various other mismatches between supply and manpower demand. The problem of vacant posts is documented in the Health Sector Assessment. Current training programs are inappropriately related to the job functions of BHC workers. Better job descriptions are needed followed by curricula based on well-identified training objectives. These deficiencies must be remedied in preparation for nationwide implementation of a basic health services delivery system. The Phase II project will provide technical assistance for the development of manpower forecasting in the MOPH. Based on the forecast, a detailed manpower and training plan will be produced.

Information Systems. Most managerial processes in the MOPH (e.g. logistics, personnel and finance) today operate in a vacuum of information. Particularly lacking is central data on field status. National implementation of a basic health care system, and the Girishk Experiment itself, demand a reliable flow of relevant information, which should be developed on the basis of a systematic, integrated analysis. An important aspect of all programs being supported under this Phase II project is the development of practical and appropriate information systems. There is not a single comprehensive information system, but numerous sub-systems that must be developed for particular planning, management and evaluation purposes. For example, there is need for an improved recording and reporting system for health service statistics, manpower and personnel projections and financial data analysis. Emphasis will be on practical management information systems which will provide MOPH managers with timely data required for decision-making. Information systems which merely collect data for some potentially useful, but unspecified, purpose will be avoided.

The problem of vacant posts has been alluded to in the previous section of this Project Paper. One objective of the Phase II project is to fill vacant technical and managerial posts with trained personnel, but the MOPH has little capability to assess its personnel resources and requirements. Its personnel record system contains a great deal of information, but is almost impossible to use for management decisions. In addition, the records are frequently out of date. It is essential that this system be improved. During the Phase II project, the existing personnel record system will be analyzed for the feasibility of implementing alternative systems, including both electronic data processing and manual systems. After the MOPH decides among the alternatives, assistance will be provided in system design, initial assembling of data, training of necessary personnel and early operation.

Attention will also be given to producing a system which will provide data useful for personnel management functions (transfers, promotions, etc.) and manpower planning. The advisors and consultants will also help in designing and installing a personnel supervisory system for trial implementation in the Girishk Region, related to the Ministry's initiatives in developing a system of incentives and rewards.

Budgeting and financial management are largely centralized functions of the MOPH, operating under general GOA regulations. Even within these guidelines, a certain amount of flexibility exists and improvements can be made. The MOPH realizes the importance of accurate and timely cost data and regular financial analysis of its programs. Some things can be achieved at an experimental level, but permanent improvement will occur only as the budgetary and financial management system is improved.

First priority will be given to projecting resource requirements for operation of a sustained national basic health delivery system, analysis of financial resource requirements and alternative sources for maintaining such a system. Second priority will be given to establishing an expenditure accounting, reporting and analysis system in Basic Health Centers and hospitals. Work has already started on this system and a "Central Financial Analysis Office" has been established by the MOPH in the Department of Administration. The MOPH has plans to add an accountant to the personnel roster of each Regional Training Center. Project assistance will be provided in developing job descriptions and in training staff and clerks located in the Regional Training Centers. Technical assistance will be offered to the Central Financial Analysis Office in developing schedules and procedures for cost recording, reporting and data analysis. The main objective is to develop realistic budgets based on sound financial data including unit cost data from the Girishk Experiment that can be used in planning rational replication.

Management Training. The need for continuing management development as well as the problem of staff turnover suggest the requirement for regular training to MOPH administrative personnel. While the emphasis in the discussion above has been on systems in the sense of tools for managerial use, Ministry staff itself must be equipped to use these systems effectively. To this end, a capacity for management training will be developed within the MOPH. Access to such training could form part of the reward for performance progress, with this training, in turn, becoming a part of the promotion process. The management training required is of three types:

- job orientation for all personnel with regard to government and MOPH policies, regulations and procedures.
- task training relating to the specific administrative tasks of the personnel's job descriptions.

- administrative skill training for top and mid-level personnel, to introduce management techniques of general applicability to a variety of responsibilities.

Under the MOPH's Seven Year National Health Plan, a management training unit was proposed. With AID support under the Phase I project, the MOPH has already designated two persons to be sent to the U.S. to be trained as management trainers. The Phase II project will provide further assistance to the MOPH in establishing an in-service training program including the three types of training listed above.

c. Outputs

See Part II, B. 4. below.

d. Inputs

What follows is a brief narrative discussion of the classes of proposed project inputs. All inputs are quantified in both the Logical Framework Matrix and in the Financial Analysis below.

Technical Assistance

The Phase II project will include financing for 11 long-term advisors to the Ministry of Public Health. Three will be assigned to Girishk and will live either there or Lashkar Gah. They include:

Girishk Field Operations

Management Advisor

The Management Advisor will be assigned to the Regional Training Center in Girishk. His counterpart will be the Director of the Regional Training Center. He will be responsible not only for advising on field operations in the region, but also on the management systems of the RTC, BHCs and village-level health delivery systems. For this he will be able to rely on the Management Team in Kabul, but it is his responsibility to advise on the design, test and then institutionalization of management systems for health delivery in the region.

Public Health Training Advisor

The Training Advisor will also be assigned to the Regional Training Center. His counterparts will be the Chiefs of the several Mobile Training Teams operating from the Center. He will be responsible for advising on the training of all village-level workers, BHC personnel and the Training Teams at the RTC. For this, he will rely on the Curriculum and Public Health Advisors in Kabul, but it is his responsibility to

advise on the planning, scheduling and implementing of all health training programs in the region. This member of the Team must have a medical degree.

Survey Analyst

The Survey Analyst will also be assigned to the Regional Training Center in Girishk. His counterpart will be the Chief Statistician in the administrative section of the RTC. He will be responsible for completing the survey design, outlining the survey technique, collecting and analyzing baseline data and assisting the RTC in the collection of health status statistics. He will also work closely with all field operations personnel and the Evaluation Team to supplement their work with the necessary data collection and analysis. He will be able to call on short-term consultants for advice as well as the Evaluation Team; but it is his responsibility to design, implement and analyze the baseline survey for Girishk.

Ministry of Public Health Operations

Health Systems Planner

The Health Systems Planner will be assigned to the Ministry of Public Health and will be counterparted to the General President of Health Services. He will also be counterparted to the Evaluation Team. He is responsible for planning, program development, operations, management and evaluation of basic health care delivery systems. He will also be responsible for integrating the various operational components of the proposed system.

Basic Health Services Management Advisor

The Management Advisor will be assigned to the Ministry of Public Health in Kabul. His counterpart will be the President of Basic Health Services. He will be responsible for advising on planning, program development and evaluation of basic health care delivery programs. In this regard, it would be helpful if he had a medical degree. He will also be responsible for management assistance in terms of Basic Health Service operations. For this, he may call upon the entire Management Team, but it will be his responsibility to establish schedules, operations and support systems for rural delivery programs with his counterpart within the Presidency.

Curriculum Advisor

The Curriculum Advisor will be assigned to the Basic Health Services Presidency in the MOPH. His counterpart will be the Training Director, BHS/MOPH. He will be responsible for training curricula for village-level and BHC personnel and operations. He will also assist in

the development of the RTC Manual for Trainers. In this regard, he will work closely with the Training Advisor in Girishk and Public Health Advisor in Kabul, but it will be his responsibility to design, test and finalize the curricula outlined in the outputs section of the Logical Framework Matrix.

Public Health Education and Communications Advisor

The Public Health Education Advisor will be assigned the Basic Health Services Presidency. His counterpart will be the Director of Training. The first assignment will be to examine all ongoing health education programs of the BHC. The Advisor will specifically advise on the "Outreach" programs of the BHC and the relationship between those programs and village-based operations. In this regard, the Advisor will assist in defining both a public health and supervisory role for the BHC sanitarian. In addition, the Advisor will explore alternative media approaches to public health education for testing in Girishk.

General Management Operations Advisor

The Management Advisor will be assigned to the Ministry of Public Health in Kabul. His counterpart will be the President of Administration. He will be responsible for the work of the Management Training, Logistics and Information Systems Advisors. He will be specifically responsible for advising on all management systems related to the support of Basic Health Services.

Management Training Advisor

The Management Training Advisor will be assigned to the Ministry of Public Health, Administration Presidency. His counterpart is to be determined. He will be responsible for the design of a Management Training Unit. He will develop training plans and curricula and will advise on the teaching program.

Logistics Systems Advisor

The Systems Advisor will be assigned to the Central Warehouse and Supply Office of the MOPH in Kabul. His responsibilities include design and implementation advice for practical modifications of the existing logistics system for rural health supply; development of operations manuals for warehousing and supply; assistance to the MOPH drug facility on distribution; and consultation with the President, Basic Health Services, on the support of regional operations.

Information Systems Advisor

The Systems Advisor will be assigned to the Ministry of Public Health in Kabul - specifically the Personnel and Financial Analysis Offices of Administration. He will be specifically responsible for analysis and improvement in the personnel record systems, MOPH expenditure accounting and analysis systems, and health service statistics collection and analysis.

Consultancies

Six categories of short-term consultancies are proposed for the Phase II project. They are described briefly below. They are subject to revision upon submission of the detailed workplan.

Planning and Evaluation

Thirty-six man-months of assistance are contemplated. A senior Health Sector Planner will be recruited with responsibility for evaluating the viability and feasibility of the Girishk Experiment for national replication. He will also assess the capacity of central ministry management systems to launch a national program. It is estimated that the Planner will spend three months each year in Afghanistan. It will be his responsibility to devise an evaluation plan of the Girishk Experiment. At the end of the project period, he will make recommendations on the basis of which a Sector Grant will be considered. The Health Sector Planner should not be from the Management Team and may be selected from AID-funded central contracts. Otherwise, solicitations will be sought and the costs financed hereunder. The Health Sector Planner will be available to work on both the workplan and Baseline Survey design. In addition to his nine man-months, twenty-seven man-months of associated consultancies are provided.

Provincial Hospital Survey

Five man-months of assistance are contemplated. The Survey will address the role of Provincial Hospitals in a Basic Health Care system and make recommendations for organization, management, staffing, training, supply and operations. On the basis of recommendations, USAID will consider amending the Phase II project to include pilot work at the four Provincial Hospitals in the Girishk Region.

Girishk Experiment

Thirty-two man-months of consultancies are contemplated. Specialities included are public health, management systems, AHDS evaluation, survey design, etc.

Basic Health Services

Sixteen man-months of consultancies are provided. Specialities included are training and curriculum, public health education, etc.

Manpower Planning

Twenty-four man-months of consulting assistance are contemplated. The planning will be under the auspices of the Planning Board of the Planning Department within the MOPH. It will be used to assist in the development of a manpower requirements analysis, manpower development strategy and training recommendations. Perhaps the most important component of those recommendations will be the assessment of current training programs across the Ministry and recommendations for improvement consistent with manpower projections.

MOPH Administration

Fourteen man-months of consultancies are contemplated. They may include financial analysis, health statistics collection and specifically planned that long-term technical assistance advisors leaving before the end of the Phase II project (e.g. logistic and information systems advisors) be brought back to Afghanistan for evaluation and follow-up assistance in the third year.

Drug Revenue Management

Twelve man-months of consultancy help are contemplated. The consultancies will be used to assist establish logistic and accounting systems for drug supply and resupply, revenue generation and allocation and general program operations. Assistance in machine operation and maintenance will be provided in the equipment contract.

Community Based Distribution

This pilot effort calls for six man-months of consultant services over the life of the project.

Participants

The participant program will be defined in the workplan. Since the bulk of training will take place in country either "on-the-job" within the Ministry or in specific training programs. Long-term regional training outside Afghanistan is not deemed necessary. There will be no long-term U.S. degree training funded under the Phase II project. To the extent such training requirements are identified during the course of the project, they will be considered for funding during the Sector Grant in FY 1982. Postponing of long-term degree training

will enable U.S. funded technical assistance advisors to work over the life of the project with their counterparts. It will also facilitate more careful assessment of real training requirements and suitable candidates.

The Project budget does contemplate short-term skill training in the United States and third-country observation training for regional workers. Again, the specifics of those programs will be outlined in the workplan.

Commodities

There are two categories of project commodities included under Phase II: contract and Ministry support. The first includes office furniture and vehicles for the Management Team.

The second category has several components:

- seven vehicles to support Mobile Training Teams in Girishk and at the other Regional Training Centers to be opened during Phase II;
- almost \$750,000 for the import of drugs to capitalize a drug revolving fund. The drugs would be sold and proceeds utilized both to replace stocks and to support village-based programs. The revolving fund is an important first step at testing "fee-for-service" in Afghanistan; and
- almost \$150,000 for drug packaging equipment to establish the domestic drug manufacturing facility which will sustain the drug program. Funds will be included in the equipment contract for installation and training.

Other Costs

The major element here are the local support costs for the Girishk Experiment. It is proposed to fund the total costs of the Home Visiting and Community Based Distribution experiments. Commodity costs for contraceptive supplies (\$100,000) will be centrally funded. It is also proposed that AID fund the per diem costs for all training and supervisory programs during the Phase II period in Girishk, as well as continuing per diem support for trainers in BHC continuing education and supervisory programs in the rest of the country. These are basically in the nature of research and design expenses and as such are appropriate for

financing. Those costs will be at existing GOA rates and will have to be included in the Government budget should we decide later to proceed with a sector grant.

Funds to complete the construction of 50 BHCs and equip three RTCs as committed under the Phase I project. The supervisory costs for construction will be included (e.g. construction supervisor per diems) as well as a commodity bonus element for unlicensed contractors. Construction is not an integral part of the Phase II project but was authorized under Phase I. Strict implementation conditions are included in Part IV Implementation Procedures.

4. Logical Framework

There follows an expanded project design summary:

Program Goal

Improved health status of the rural population.

Measures of Goal Achievement

	<u>Baseline</u>	<u>Follow-up Target 1985</u>
1. <u>Mortality</u> Age-specific age group (0-4 age group)	-	25% decrease
2. <u>Morbidity</u> Malnutrition (1-5 age group)	-	50% decrease
Immunization (1-5 age group)	-	50% immunized
3. <u>Fertility</u> Continuing Users	-	25% continuing
4. <u>Knowledge & Health Practices</u>	To be determined in design of the Baseline Survey.	

Means of Verification

Baseline survey in 1979 repeated in 1981 and again in 1985.

Important Assumptions

That the Government of Afghanistan adopts and supports a national health care system in accord with its stated aims.

Project Purpose

1. Initiate and sustain a basic health care system in a region directed at the major health problems of the region; which provides preventive, curative and referral services to a majority of the rural population, and which could constitute a feasible and viable model for national replication.
2. Development of a management system within MOPH capable of supporting a regional health care system and then subsequently launching a national health care system.

End of Project Status

1. Regional Basic Health Care System
 - A. Basic health care system functioning in the Girishk Region
 - A1. 90% of VHWs resupplying drug needs
 - A2. 75% of VHWs and Dais making referrals to BHCs
 - A3. Sanitarians actively providing health education within a 10 km. radius of BHCs
 - A4. Sanitarians or other BHC workers actively supervising 90% of VHWs and Dais
 - A5. 50% of MOPH installed or supervised water supplies remain sources of clean water
 - A6. 25 operational BHCs, as evidenced by:
 - 90% drug list available
 - 90% recommended equipment available and operational
 - fully staffed and trained in use of BHC manual
 - financial and health service statistics submitted to RTC on a timely basis
 - A7. All BHCs actively referring clients to Provincial Hospitals
 - A8. Two RTC training/supervisory teams visiting BHC at least quarterly
 - A9. Regularly scheduled pre-assignment training for all BHC workers by RTC

- A10. Two RTC training teams operating on scheduled basis for initial training, retraining and replacement training of VHWs and Dais.
- A11. Fully staffed RTC Administrative Section receiving and transmitting on a timely basis:
 - drug inventories, fees and data
 - health, family planning service statistics
 - financial data
 - personnel data
- B. Health care system directed at major health problems
 - B1. See A1, A2., A3., and A4. above.
 - B2. Home Visiting Program experiment operating in catchment area of 5 BHCs.
 - B3. Community Based Distribution experiment operating in catchment area of 5 BHCs.
 - B4. MCH clinic operating in all 25 BHCs.
 - B5. Oral Rehydration room operating in all 25 BHCs.
 - B6. Health Education Program associated with MCH and WFP at all distribution points.
- C. Health care system directed at a majority of the population.
 - C1. VHWs and Dais accessible to 75% of the rural population of the region.
- 2. Management Systems
 - A. MOPH Basic Health Services Presidency operating effectively as evidenced by 1A, B and C above, and 2B, C and D below.
 - A1. Evaluation team will identify additional operating criteria to be used as means of verification.
 - B. MOPH logistics system operating effectively as evidenced by:
 - B1. Drug and contraceptive supply assured to BHC as evidenced by receipt of 100% of requests and 90% drug list availability in all BHCs.

- B2. Supply systems rationalized as evidenced by receipt of 100% of requests and 90% recommended equipment list available in all BHCs.
- C. MOPH information systems operating as evidenced by:
 - C1. Personnel records rationalized as evidenced by records being utilized for planning, assignments, training and promotions.
 - C2. Financial/accounting systems rationalized as evidenced by receipt/utilization information programming, planning and budgeting.
 - C3. Health service statistics rationalized as evidenced by compilation and utilization in programming, planning and budgeting.
- D. MOPH manpower plan is being utilized for staffing and training of a national health system.
- E. Information is generated to determine whether a feasible and viable basic health service model exists for national replication as evidenced by:
 - E1. GOA analyzing and considering Girishk Experiment and management systems in terms of their technical feasibility and financial viability.

Means of Verification

1 and 2-2A.

Regularly scheduled field and record checks and independent evaluation throughout.

2B - D.

Independent evaluation throughout.

2E. Baseline Survey and independent evaluation

Important Assumptions

- 1. That the Government of Afghanistan is committed to a national health care policy.

2. Non-health factors (e.g. low income, tradition, etc.) are not such as to frustrate improvements in health status arising from a national health care system.
3. That a national health care system directed to the health problems of women and children will, in fact, also be indicative of the health status of the entire population.
4. That Afghan women will utilize the services of a national health care system.

OutputsMagnitude

1. Training capacity

1.1 Curriculum, training plans and manuals completed for:

N/A

a - VHW/Dai (continuing education)

b - BHC pre-assignment

c - sanitation supervision

d - BHC (continuing education)

e - BHC public health education

f - RTC training of trainers manual

g - MOPH Management Training Unit

h - Logistic system manuals

i - Information system manuals

1.2 MOPH Management Training Unit established

N/A

2. Trained health manpower

2.1 VHWs/Dais recruited and trained in Girishk

350 VHW
650 Dai (estimated)

2.2 Non-physician managers trained and assigned in Girishk

12

2.3 All staff of 25 BHCs in Girishk given pre-assignment training

250 BHC Workers

2.4 Regularly scheduled continuing education for all BHC employees in Girishk

400 BHC Workers

2.5 Training staff of Girishk RTC training completed

35 RTC Workers

2.5 Regularly scheduled continuing education for VHWs/Dais in Girishk

1000 village-level workers

	<u>Magnitude</u>
2.7 Central ministry staff trained	OJT
3. Management Systems	
3.1 Drug packaging operation established	N/A
3.2 Revolving fund for drug purchases established for Girishk region	\$750,000
3.3 90% recommended equipment and supplies in place in all BHCs and RTC in Girishk	N/A
3.4 Manpower analysis, projections and training recommendations completed	N/A
3.5 Survey of Provincial Hospitals completed	N/A
3.6 Home Visiting Program experiment initiated in 5 BHCs in Girishk	N/A
3.7 Community Based Distribution experiment initiated in 5 BHCs in Girishk	N/A
3.8 MCH clinics established in all 25 BHCs in Girishk	N/A
3.9 Nutrition/oral rehydration rooms established in all 25 BHCs in Girishk	N/A
3.10 Baseline survey (1979) and follow-up (1981) complete in Girishk	N/A
3.11 Work and Evaluation Plans completed and approved	N/A
3.12 Final Report, including detailed recommendations for replication of national health care system completed and submitted for Government consideration	N/A
4. Physical Infrastructure	
4.1 Nine BHC completed in Girishk	N/A
4.2 Forty-one BHC completed pursuant to Phase I PP..	N/A

Means of Verification

Internal project data, project manager certification, field and record checks, field surveys and independent evaluation.

Important Assumptions

1. That Girishk is not atypical and that results of the experiment will constitute a relevant test of the feasibility and viability of a national system.
2. That health personnel can be recruited and will stay in place.
3. That incentives will be sufficient to retain VHWs and Dais in the system.
4. That physicians in the BHC will allow authority to be delegated away to non-physician managers.
5. That the Government of Afghanistan is not prepared to consider "fee for service" at this time.

Inputs

	Years (FY)	1	2	3
1. Technical Assistance				
A. Advisors	(M/M)			
Management Advisor G		12	12	12
P.H. Training Advisor G		12	12	12
Survey Analyst G		12	12	12
Health Systems Planner		12	12	12
BHS Management Advisor		12	12	12
Curriculum Advisor		12	12	12
P.H. Education Advisor		12	12	12
Management Operations Advisor		12	12	12
Management Training Advisor		6	12	6
Logistics S Advisor		12	12	-
Information S Advisor		12	12	-
		-----	-----	-----
		126	132	102
	Costs (\$000)	1.323	1.165	.945
B. Consultants	(M/M)			
Planning and Evaluation		12	12	12
Provincial Hospital Survey		5	-	-
Girishk		14	11	7
Basic Health Services		4	6	6
Manpower Planning		6	12	6
MOPH Administration		5	5	4
Drug Revenue Mgt.		6	6	-
Community B. Dist.		-	3	3
		-----	-----	-----
		52	55	38
	Costs (\$000)	.562	.623	.450
C. Local Contract Staff	(M/M)			
AHDS Advisor G		12	12	12
Survey Team Supervisor		12	12	12
AHDS Advisor, MOPH		60	60	60
Management Training Advisor		12	12	12
Sr. Data Analyst		12	12	12
		-----	-----	-----
		108	108	108
	Costs (\$000)	.077	.081	.085

	Years (FY)	1	2	3
D. Home Office Expense				
	Costs (\$000)	.228	.202	.250
2. Participant Training	(M/M)			
U.S. Training		77	153	135
Third Country Training		60	49	29
		—	—	—
		137	202	169
	Costs (\$000)	.237	.437	.397
3. Project Commodities	Costs (\$000)			
Vehicles (3G/4 Kabul)		.074	-	-
Pharmaceuticals		.475	.275	-
Home Visiting Program Supplies		.059	.081	.098
Other:				
Warehouse & Packaging Equipment		.143	-	-
Drug Cabinets (375)		.053	-	-
Office Equipment		.014	-	-
Injection/First Aid Kits		.012	-	-
Bicycles (350)		.033	-	-
Calculators/Typewriters		.013	-	-
Motorcycles (25)		.018	-	-
Clip Books and Posters		.023	-	-
		—	—	—
	Costs (\$000)	.917	.356	.098
4. Construction	(Number)			
Girishk Basic Health Center		9	-	-
Other Basic Health Centers		20	21	-
Construction Supervisor		N/A	N/A	-
Construction Equipment		N/A	-	-
Drug Storage		1	-	-
		—	—	—
	Costs (\$000)	.871	1.101	1.385

	Years (FY)	1	2	3
5. Contractor Support Costs				
Vehicles (5)		31	24	-
Equipment and Supplies		134	072	062
Support Staff		141	147	154
Other Advisor - per diems)		150	142	124
		-----	-----	-----
Costs(\$000)		.456	.385	.340
6. Project Local Costs				
Training Support - Girishk		.067	.073	.087
Training Support - National		.044	.042	.041
CBD - Girishk		.107	.110	.133
Other		70	79	98
		-----	-----	-----
Costs (\$000)		.288	.304	.359

Means of Verification

Project records and audit tracking.

Important Assumptions

Appropriate numbers of personnel can be recruited.

PROJECT DESIGN SUMMARY
LOGICAL FRAMEWORK

Life of Project:
From FY 78 to FY 80
Total U. S. Funding _____
Date Prepared: May 30, 1978

Project Title & Number: BASIC HEALTH SERVICES PHASE II: 306-0144

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
<p>Program or Sector Goal: The broader objective to which this project contributes: Improved health status of the rural population</p>	<p>Measures of Goal Achievement:</p> <ol style="list-style-type: none"> 1. Mortality 2. Morbidity 3. Fertility 4. Knowledge and Health Practices 	<p>Baseline Survey in 1979 repeated again in 1981 and again in 1985.</p>	<p>Assumptions for achieving goal targets: That the Government of Afghanistan adopts and supports a national health care system in accord with its stated aims.</p>
<p>Project Purpose:</p> <ol style="list-style-type: none"> 1. Initiate and sustain a basic health care system in a region. 2. Develop a management system capable of launching a national health care system. 	<p>Conditions that will indicate purpose has been achieved: End of project status.</p> <ol style="list-style-type: none"> 1. Regional Basic Health Care system in Girishk. 2. Management systems operating within the MOPH. 	<p>Regularly scheduled field and record checks and independent evaluation throughout.</p>	<p>Assumptions for achieving purpose:</p> <ol style="list-style-type: none"> 1. That the Government of Afghanistan is committed to a national health care policy. 2. Non-health factors are not such as to frustrate improvements in health status arising from a national health care system.
<p>Outputs:</p> <ol style="list-style-type: none"> 1. Training capacity 2. Trained health manpower 3. Management systems 4. Physical infrastructure 	<p>Magnitude of Output: See expanded outputs following.</p>	<p>Internal project data, project manager certification, field and record checks, field surveys and independent evaluation.</p>	<p>Assumptions for achieving outputs:</p> <ol style="list-style-type: none"> 1. That Girishk is not atypical. 2. That personnel can be recruited. 3. That incentives exist for VWs and Dais 4. That non-physician managers can operate. 5. That "fee-for-service" is not yet possible.
<p>Inputs:</p> <ol style="list-style-type: none"> 1. Technical assistance 2. Participants 3. Commodities 4. Other Costs 	<p>Implementation Target (Type and Quantity) See Part III D of Project Paper following.</p>	<p>Project records and audit tracking</p>	<p>Assumptions for providing inputs: Appropriate numbers of personnel can be recruited.</p>

PART III - PROJECT FEASIBILITY ANALYSES

A. Technical Analysis

Afghanistan has one of the most difficult health situations in the world. The situation calls for a system of simple low-cost preventive health measures. The previous regime had taken the complex high-cost curative health approach with the consequence that health services are inequitably distributed, largely inappropriate and inefficient. However, there is now an awareness of this and an impressive beginning has been made through introduction of a basic health care delivery system. It is the purpose of this section to assess the feasibility of that proposal. The Mission Health Sector Assessment, March 1978, is fundamental to the assessment and should be read in association with this section.

1. The Strategy

The Phase II project is designed to test the Government's proposed basic health services strategy and to strengthen management systems to facilitate its national replication should it prove feasible and viable. The project, then is a feasibility test and will be used to support a Sector Grant for national replication in FY 1982.

The Phase II project will test the strategy by supporting regional curative and preventive services through a three-tiered system that can greatly increase the accessibility, outreach and quality of rural health care at reasonable cost. Health status is a function of many variables. Providing curative services alone will not significantly alter morbidity and mortality patterns. Because the Phase II project emphasizes preventive care with maximum outreach, a major public health impact can be achieved on maternal mortality, fertility, prenatal and infant mortality and the children under five. On this basis, together with the support and apparent commitment of Government, the proposed basic health services strategy can be viewed as prima facie feasible and a justifiable means of improving the health status of Afghanistan's rural poor.

2. The Village-level Health Delivery System

Evidence from a wide variety of countries in both the developed and developing world has established that the use of paramedics or physician extenders is an effective means of providing good quality health care. The experience of Medex, physician's assistants, and nurse practitioners in the United States indicates that these workers can significantly increase the productivity of the physician and thus reduce the cost per unit of service. The dramatic achievements of the Chinese "barefoot doctors" is

evidence of the effectiveness of deploying large cadres of health workers within a well defined operating system. Many countries throughout the developing world have used non-physician health providers with considerable success. In the Afghan context, workers have achieved good social acceptance when logistically supported. When experimental programs failed, it was largely because of inadequate planning and preparations or because of administrative and financial problems which have been addressed in the Phase II project design.

Issues include:

a. Community Framework

Lack of success with village-level paramedics can most frequently be traced to inadequate preparation of the worker, the health services system and/or the community for this new approach to health care. The Phase II project will assure clearcut job descriptions, scheduled training, continuing education and active supervision from the BHC. Careful attention will be given to imparting to each village-level worker ethical concern for his or her assignment and for public health. Village Committees will be organized to recruit, select, monitor and control drug prices. An active communication strategy is also planned to orient community residents and leaders to the functions of the village-level workers. It is our premise that these efforts will ensure greater community support.

b. Training

Quality care is an issue raised over and over again in assessing village-level programs. Most of the problems that Village Health Workers and Dais will face can be treated without extensive knowledge of body systems and specific disease processes. Training these village-level workers to deal with health problems rather than disease processes is therefore appropriate. Competency based training materials developed to date emphasize the development of skills and knowledge to meet basic levels of performance that can easily be standardized for national replication.

c. Recruitment and Deployment

Lack of effective recruitment and deployment systems is a common cause of program failure. This problem is particularly complex in Afghanistan because of the need to have female workers for village women and children, and is compounded by the restrictions on the role of women. This will remain a problem until the overall role of women in the socio-cultural setting in Afghanistan changes. Evidence of

change has been noted in increased applications for female family planning positions, in the Mission's recent anthropologic enquiry and the stated intentions of the new Government.

d. Remuneration

The proposed village-level system is premised upon community support. Although the past Government was unwilling to test "fee-for-service", and the new Government's early pronouncements suggest a similar position, there may be a willingness to introduce and test a payment for drugs scheme. The Village Health Worker proposal is premised on generating income for the worker from the sale of drugs at Government established prices. Prices would be controlled by the Village Committees. The Dai, of course, already receives a fee for her service, but Home Visiting and Community Based Distribution must find alternative revenue sources. Sales of drugs at the BHCs could generate small surpluses to support these preventive programs. Without commitment to revenue schemes such as drug sales, the financial underpinning for the village-level health delivery system becomes much more tenuous.

e. Population Programs

At the village level, it is proposed that the traditional midwife, Dai, be responsible for maternal child health (e.g. home visiting) and contraception delivery (e.g. community based distribution). With the Dai supported by fees for birth delivery, there may be an inherent contradiction in placing responsibility with her for fertility changes. The incentives are not obvious, and it is an element of the Phase II test that should be examined very closely.

f. Supervision

Supervision is both remote (i.e., BHC) and assigned to a para-medical (i.e., sanitarian). In this circumstance, the quality of village health care and appropriateness of drugs that have been dispensed are at issue. It is at least conceivable that villagers may be paying more and receiving less than under less formal health systems. The training advisor and survey analyst in Girishk will monitor closely the quality of health care in the village.

3. The District-level Basic Health Centers

The Ministry of Public Health now has 121 Basic Health Centers with plans to expand to about 200 within the next five years. As noted earlier, their effective catchment area is only 10 kilometers and their outreach services are limited if not non-existent. There have been two

proposals to extend their coverage: village-level systems and sub-centers. The test proposed for Phase II is village-level systems. To test sub-centers would probably overextend the BHC system before it gets a chance to establish itself firmly. Although 73 such sub-centers existed on paper by late 1977, very few if any were operational. Management problems including transportation and accommodations, not to mention shortages of drugs and manpower, currently plague the program. Given the numerous constraints under which the BHC program and MOPH in general operate, it makes better sense to delay implementation of the sub-centers and concentrate on consolidating the existing BHC program. This is proposed during Phase II. It will be accomplished by proper staffing, adequate supplies of drugs, and outreach activities such as increased participation in community affairs, vaccination programs in local schools, and home visiting by Dais to impress on the rural population the necessity of improved nutrition, hygiene, sanitation and family planning.

Issues include:

a. Catchment Area

The catchment area of the typical BHC is only 10 kilometers. Utilization of skilled curative staff is both inefficient and inequitable in this circumstance. Financial limitations in the past have restricted the possibilities of expanding the BHC system. Therefore, referrals to the Center must increase. The village-level program is critical to that effort. Secondly, the BHC must reorient itself towards preventive work. The catchment area for preventive programs should be significantly greater than the current curative catchment. Preventive programs are limited to facility-based activities presently, but outreach is an untapped area that must be explored during the Phase II period. In sum, the feasibility of the BHC is premised on a vibrant village program and reorientation of the current BHC. Without that commitment, the BHC provides only curative care to a small population surrounding it.

b. Manpower

The Basic Health Care System proposed for Phase II is not autarkic. It is based on a supply of trained manpower from the education sector and from the training institutions of the Ministry of Public Health. For example, our analysis indicates there will be a shortage of trained sanitarian and male nurses in the Phase II project period. The Phase II project cannot address that issue other than to sponsor the analysis of requirements and the relationship to existing and planned training programs. It may be that investments in health education per se will be an important infrastructure component of any basic health strategy. USAID is prepared to propose health education projects as requirements are identified and related to the basic health strategy.

c. Vertical Programs

Each BHC has two vaccinators assigned. To date, their service is basically facility-based. This is a reflection of the current orientation of BHCs but also of the tension between the proposed basic health services strategy and vertical programs. The Phase II project does not address this critical issue although it is a central policy concern that must be resolved before national replication of a basic health services program. It is obvious, for example, that possibly the major preventive tool for meeting the project goal is immunization. Yet facility-based immunization reaches less than seven percent of the rural population. Integration is a proposal often suggested, but it cannot even be tested until sufficient members of village and facility-based workers are trained, deployed and BHCs are increasingly in place in the rural areas. During Phase II, the USAID Mission will explore this obvious issue with the Ministry Management Team and other donors. Opportunities for cooperation with rural water and malaria programs are other examples that must be addressed.

4. Regional Training Center

The Regional Training Center is the principal managerial and technical support point in the region. At the moment it is responsible for village-level training and BHC training and supervision. It will also be the point for regional supply and control of drugs, other supplies and equipment. In addition, the MOPH plans call for including regional health planning and disease surveillance in the RTC. In effect, it is the first step towards decentralization. It is recognized that this is a step the MOPH is moving towards. The role of the Provincial Health Officer, must be rationalized, and the relationship between Preventive and Curative Medicine in Kabul will have to be resolved.^{1/} These are issues that will be considered over the three-year life-of-project, and they must be resolved before AID could consider a Sector Grant in support of national replication.

Issues include:

a. Operational Costs

A major element of cost in the Girishk Experiment is local support (e.g. per diems for mobile training teams, village-workers, etc.). While appropriate for AID financing during the experimental phase, they are costs which the MOPH will gradually have to include in its budget if the program is to be introduced nationally. During the Phase II project, the actual costs of the program will be carefully monitored, alternate levels of support will be tested and the Government will actually begin to incorporate these costs into its budget. It is mentioned here, because, like fee-for-service or a drugs-for-fee system, the recurrent costs of the proposed system will be the key to assessing system viability.

^{1/} See Part II, B.2.c for a more complete discussion of this issue.

b. Girishk Assignments

The project design specifies the assignment of three full-time technical assistance advisors to Girishk. Members of the current Management Team have argued that this will "over-load" the system and have taken the position that only the Field Operations Chief should be assigned to Girishk. The Regional Training Advisor and Survey Analyst should remain in Kabul. The Mission has maintained its position on the following grounds: (i) with almost 1,000 village-workers to be recruited and trained and over 400 BHC personnel to be trained and supervised, the Training Advisor would be required to spend more than half of his time in Girishk. Also note Girishk encompasses a quarter of the country and over 15 percent of the population. In addition, we believe that he should be close to the regional workers to better understand the nature of their assignment, problems and training requirements. (ii) The Survey Analyst will have responsibility for measuring both health impact and the costs of operating the system. The baseline work itself will consume almost half his time, and we believe he can be useful in assessing short-term alternative approaches (e.g. variable public health education techniques of sanitarians, etc.). (iii) If the RTC is to represent a decentralization of the system, then the capacity must exist in the Center to carry out its functions without constant referral to Kabul. As noted earlier, the personnel may actually live in Lashkar Gah where AID already has a substantial contingent with the Soil Conservation Service.

5. Ministry of Public Health

The Logical Framework reflects the need for improved management of the basic health care system. A detailed strategy for improving health services administration, particularly at the national level, is spelled out in the project description. With careful monitoring, this approach should be successful in establishing the management support for a sound basic health services system.

Issues include:

a. Team Size and Composition

The original Ministry proposal was for 17 full time resident advisors. Following discussions and careful analysis, the Project Committee recommended the 11 proposed in this Project Paper. It is believed they provide basic coverage to the core areas of concern in the Phase II project. Those not included are discussed below:

- drug operations advisor: The Project Committee has proposed to include mechanical operations advice as part of the equipment package. In requesting bids, the Government will also request the services of a manufacturer's representative to assist in equipment installation, initial operation and maintenance. The Logistics Advisor with the MOPH will assist in warehousing and delivery. The Information Systems Advisor will be available to advise on management systems and the Revolving Fund. In addition, 12 man-months of consultancy services are provided to assist in drug revenue management.
- management support, BHS/MOPH: The Project Committee believes this assignment can be covered by the BHS Operations Advisor. Management's systems support within BHS can be sought from the Logistic and Information Systems Advisors included with the MOPH team. On the other hand, USAID has included a Village Programs Advisor to assume responsibility for this critical new element in the basic health-level delivery system.
- alternative health delivery systems advisor: while additional analysis of other alternative delivery systems is clearly advisable, it is the judgment of the Project Committee that the current project should focus on intensive testing of the proposed basic health services model.
- provincial hospitals advisor: as discussed earlier, the Phase II project includes financing for a short-term study and contemplates the possible amendment of the Phase II project based on the findings of that study.
- construction advisor: as discussed earlier, the Project Committee believes that a construction advisor is neither necessary to the purposes of the project nor the successful completion of BHC construction. On the other hand, USAID will finance supervisory support costs as well as an incentive program for unlicensed contractors.
- chief of party: The COP should be counterparted to the Deputy Minister of Health and should be one of the 11 full-time advisors. Adequate funding is

provided for administrative management. Whether the COP should be the BHS Management Advisor, General Management Operations Advisor or Health Planning Advisor is left as an issue to contract negotiations.

b. Management Assistance: Scope of Services

The Phase II project has two purposes: execute a regional experiment in Girishk and strengthening of MOPH systems in anticipation of national replication. In that regard the Management Team in Kabul will obviously have concerns with central systems that will have relevance beyond Girishk and which will call for management assistance on programs outside Girishk (e.g. RTC operations in Balkh, etc.). In preparing the workplan, the scope of those assignments will be defined and related to the Phase II project purpose. For purposes of project evaluation, the test of central Ministry systems will be in Girishk. For purposes of system evaluation and feasibility assessment prior to national implication and Sector Grant support, the broader capacity of the MOPH will be considered. The Project Committee does not see conflict in terms of the scope of services for the Management Team between the test chosen for project purposes and the test chosen for Sector Grant purposes. Where there may be conflict is in the way the Ministry chooses to use the Team. During the Phase I project, the Team operated as operational advisors. They were available to the MOPH to address current operational problems and their examination of alternate health delivery systems reflected an unstructured relationship to Ministry research goals. This was entirely appropriate given the uncertain state-of-the-art and the necessity to identify problems and conceptualize solutions. It is the purpose of Phase II, based on that successful Phase I, to structure a test of health and management systems. That calls for a more formalized workplan and systems evaluation. The Project Committee believes that the workplan is key in formalizing understanding on this fundamental shift in use of technical assistance.

6. Program Operation and Maintenance

The technology required in the proposed project imposes no unusual operation and maintenance constraints on the government. The major constraints to initiation of training programs is the educational materials and teaching methodology, both inadequate testing and refinement of which will be overcome early in the Phase II project. Maintaining an expanded rural health system poses management problems, obviously, but these are clearly addressed in the management support strategy as described in the Project Description above. The other area of concern relates to recurrent costs which is addressed in the Economic Analysis section below.

7. Environmental Assessment

The Phase II project has no significant detrimental effects on the environment. Basic Health Centers which will be located in villages are of modest size and will be constructed of local materials. In the Phase II project, public health education will be initiated which will foster environmental sanitation and personal hygiene and should yield positive local environmental effects.

8. Technical Cost/Design Analysis

A detailed Financial Plan, Economic and Social Analyses are presented in the following sections of the Project Paper. Detailed project-related research was done during the Phase I project. The Management Team, World Bank, United Nations and AID staff have over a period of months reviewed Afghanistan's health needs, alternate health delivery modes and other training requirements. Technical discussions were also held with Government, AID/W and the Management Team. These efforts lead USAID/Afghanistan to the conclusion that the Phase II project proposal is technically sound and one suited to the problems, needs and wishes of the Government. The project as designed is technically and economically sound and cost estimates are reasonable. The Phase II project meets the requirements of FAA Section C11(a) and(b).

B. Financial Analysis

1. Recurrent Budget Implications

Since a purpose of this project is to test the viability of the proposed basic health care delivery system for nationwide replication, the financial implications for the recurrent budget are extremely important. The main aim of this analysis is to assess the financial implications and the GOA's capacity to finance the basic health service system. To do this the recent health budgetary performance is analyzed with regard to both overall commitment of resources to the MCPH and the internal allocation of the health budget. Performance is then compared to the commitment required to finance a nationwide basic health system. It should be emphasized that this analysis is not concerned with project costs but with the financial implications of a nationwide system based on the Girishk model.

a. MCPH Budget

As shown in Table B.1, the total budget for 1973/79 is Afs. 1.004 million, a 20 percent increase over 1977/78. Of this, Afs. 649 million is for the development budget. These figures exclude certain fringe benefits paid by the Government which amounts to 20-25 percent of salaries. Health expenditures by other GOA agencies such as the Medical School system and the Ministry of Defense hospital system are similarly excluded.

The overall MOPH budget has increased by 22 percent per annum for the period 1973-1979. Of this total, the recurrent budget has increased by 12.3 percent and the development budget by 30 percent. In 1977/78, the last year with available comparative budget data, the budget of the MOPH amounted to only 2.5 percent of the total GOA budget. The 1977/78 ordinary health budget was only 2.1 percent of projected domestic revenue. Thus, while the MOPH health budget has been growing relatively rapidly, it is still small compared to domestic revenue and overall budgetary allocations of the GOA.

The evidence of GOA priority recently assigned to health, as indicated by the relative allocation of resources to health vis a vis the total GOA budgetary allocations is ambiguous. Over the period 1973/74-1977/78 the MOPH budget rose less rapidly than did the overall budget as evidenced by the indexes in Table B.2. In 1978/79, however, the overall development budget rose by less than one percent while the MOPH development expanded by 25 percent. This may signal a rapidly increasing interest by the GOA in the health problems of the country.

It has been argued that the reduced allocations to health were the result of the MOPH to utilize budgetary resources made available to it. This problem became obvious in 1974/75 when only 57 percent of the MOPH domestically financed development budget was implemented compared to implementation rates of 82 and 75 percent respectively in 1972/73 and 1973/74.

TABLE B.1 MOPH and Total GOA Budget for 1973/74-1978/79

(million afs)

<u>MOPH Budget</u>	<u>1973/74</u>	<u>1974/75</u>	<u>1975/76</u>	<u>1976/77</u>	<u>1977/78</u>	<u>1978/79</u>
Ordinary	200	200	251	273	315	354
Development	177	-	216	287	519	650
TOTAL	377	-	467	560	834	1,004
<u>GOA Budget</u>						
Ordinary	6,690	7,311	9,855	11,170	12,500	-
Development	4,865	4,985	9,321	14,027	20,232	20,400
TOTAL	11,555	12,296	19,176	25,197	32,732	-

TABLE B.2 Index of MOPH and Total Budget (1973/74 = 100)

	<u>1973/74</u>	<u>1974/75</u>	<u>1975/76</u>	<u>1976/77</u>	<u>1977/78</u>	<u>1978/79</u>
<u>Health</u>						
Ordinary	100	100	126	136	158	177
Development	100	-	122	162	293	367
TOTAL	100	-	124	149	221	266
<u>Overall</u>						
Ordinary	100	109	147	167	187	-
Development	100	102	192	288	417	419
TOTAL	100	106	166	218	283	-

Whether or not the poor development expenditure performance is continuing is not known since 1975/76, in which development expenditures were only 45 percent of budgetary allocation, is the last year for which data are available. There are indications that actual development expenditures by the GOA for all ministries averaged only about 35 percent of budgeted amounts in 1977/78. The MOPH performance is not likely to have been significantly better than average.^{1/} If this explanation of the relatively lower budgetary allocations during the mid 1970's is correct, it would mean that health perhaps never suffered a reduction in priority. In any event in the 1978/79 budget, health seems to have become a very high priority item even though the implementation record of the MOPH has probably not improved significantly.

b. Internal Allocation of MOPH Budget

From a financial standpoint, the Phase II project is concerned primarily with the recurrent budget requirements of the Basic Health Services (BHS) of the MOPH. In 1977/78 the BHS budget was Afs. 54.8 million. (See Table B.3.) The 1978/79 budget for BHS is Afs. 68.3 million, of which 84 percent is for basic health center operations and 16 percent for central office operations. In 1977/78 BHS received 17.4 percent of the total recurrent budget; in 1978/79, this was raised to 19.3 percent as the BHS budget expanded by 25 percent.^{2/} While the share of the total recurrent budget attributable directly to the BHS is quite small, the increased share for BHS in 1978/79 indicates an expanding awareness of the need to provide adequate support to the BHS even at the relative expense of more traditional activities of the MOPH.

c. Recurrent Cost of Nationwide BHS

The foregoing sections established that the GOA appears to be increasing the priority assigned to health care in general. Equally important, within the health budget there appears to be a shifting allocation of financial resources toward the BHS. However, the Girishk regional model, if expanded to a nationwide system, implies a dramatic increase in the level of health care available to the rural population of Afghanistan and a concomitant rise in BHS recurrent financial requirements.

^{1/} The Ministry of Planning has indicated that the 1978/79 development budget would reflect a more accurate assessment of implementation capacity. This explains the increase of less than one percent in the overall GOA development budget for 1978/79.

^{2/} Certain recurrent costs of BHS are contained in other line items. Repair of vehicles is contained in the Central workshop line item for example.

M.O.P.H. Ordinary Budget
1977/78 and 1978/79

Department/Program	1977/78	Percent of Total	1978/79	Percent of Total	Percent Change 77 to 79
Minister's Office	1,477	0.47	1,511	0.43	2.26
Administration	27,633	8.77	27,055	7.64	- 2.09
Central Workshop	6,045	1.92	9,859	2.79	63.09
World Food Program	303	0.10	422	0.12	38.89
Planning	4,573	1.45	5,867	1.66	28.28
Foreign Relations	383	0.12	515	0.15	34.30
Inspection	944	0.30	1,196	0.34	26.59
Public Health Inst.	14,533	4.62	13,778	3.89	- 5.32
Mental Health	-0-	-0-	6,130	1.73	
Nursing <u>1/</u>	12,464	3.96	12,829	3.62	2.92
Curative Medicine	178,130	56.55	191,924	54.22	7.74
(Central Office)	(9,345)	(2.97)	(11,607)	(3.28)	(24.20)
(Kabu' Hospitals) <u>2/</u>	(78,216)	(24.33)	(81,618)	(23.06)	(4.35)
(Provincial Hosp.)	(71,427)	(22.68)	(79,556)	(22.47)	(11.38)
(Other Programs)	(19,141)	(6.03)	(19,142)	(5.41)	(0)
Preventive Medicine	13,709	4.35	14,576	4.12	6.32
Basic Health Services	54,779	17.39	68,333	19.30	24.75
(Central Office)	(11,371)	(3.61)	(10,897)	(3.08)	(-4.17)
(Basic Health Centers)	(43,406)	(13.78)	(57,436)	(16.22)	(32.32)
Grand Total	315,000	100%	354,000	100%	12.38

1/ Nursing includes Central Office, Post Basic, ANM School and N.M. Schools

2/ Kabul Hospitals include Prison, Sanitarium for Women, and 5 other hospitals: Jamhoriyat, Mazir Akbar Khan, Hashem Zejantoon, Child Health Institute, and Paghman Hospital.

TABLE B.4

Costs of Basic Health Centers
(000 afs)

<u>B H C</u>	<u>Recurrent</u>	<u>Depreciation</u>	<u>Capital</u>
Staff			
Doctor	38.4		
Nurse	30.6		
ANM	25.2		
Sanitarian	30.6		
Vaccinators (2)	61.2		
Manager	38.4		
Admin Clerk	27.0		
Maintenance	14.1		
Driver	21.0		
Storekeeper	21.0		
TOTAL	<u>307.6</u> <u>b/</u>		
1 Vehicle		42.0	210,000 (5 yr)
2 Motorcycles		16.8	84,000 (5 yr)
Equipment (basic)		3.6	36,414 (10yr)
Oral Rehydration		0.4	4,475 (10yr)
Oral Rehydration Training Aids		0.3	1,342 (5 yr)
Furniture		10.6	105,800 (10yr)
Building Depreciation		105.0	3,150.7 (30 yr)
Supplies		11.4	
Vehicle Operation 8,000 mi @ 10 afs/mi	80.0		
Motorcycle Operation @ 3 afs/mi 5000 mi x 2	30.0		
Information Systems ^a	2.4		
Building Maintenance ^a	8.0		
Drugs	800.0		
Oral Rehydration Expendables	37.7		
Per Diems			
VHM Supervision	14.6		
Dai Supervision	26.0		
Other	20.0		
TOTAL	<u>1,337.6</u>	<u>178.7</u>	

a/ From BHC I Project Paper.

b/ excludes 25% fringe

TABLE B.5

VHW/Dai Costs
(000 afs)

<u>Per BHC</u>	<u>Recurrent</u>	<u>Depreciation</u>	<u>Non- Recurrent</u>
14 VHW Training	-		36.4
10% replacement	3.6		
Continuing education	7.3		
Kits		14.7	147.0
Lost/New Trainee Kits	29.4		
25 Dai Original Training			113.8
10% replacement	11.4		
Continuing education	<u>16.3</u>		
TOTAL	68.0	<u>14.7</u>	

TABLE B.6

Regional Training Center Costs
(afs 000's)

a. <u>Staff</u> ^{a/}	<u>Recurrent</u>	<u>Depreciation</u>	<u>Capital</u>
Chief	42.0		
VHW training team	109.6		
Dai training team	109.6		
Formal training team	103.5		
Mobile training team	385.9		
Management	691.4		
sub-Total	<u>1,442.0</u> ^{b/}		
b. <u>Vehicles and Equipment</u>			
Vehicles		126.0	630.0 (5 yr)
Building		105.0	3,150.0 (30yr)
Equipment		17.4	174.3 (10yr)
Furniture		17.4	174.4 (10yr)
Operation Vehicle	300.0		
Supplies	45.5		
Building Maintenance	27.0		
c. <u>Per Diems</u>			
Mobile training/supervisory teams	397.8		
Continuing Ed BHC staff	348.8		
Central staff training for BHC	66.6		
TOTAL	2,627.7	265.9	

a) Staffing pattern assumed to be 50 percent greater than currently (except for chief) since current staffing pattern geared to 200 rather than 300 centers.

b) Excludes 25% fringe.

BNS DEPARTMENT COSTS
(afs 000's)

Staff ^{a/}	Recurrent	Depreciation	Capital
President	66.6		
Dept. President	38.4		
Pres. Office	141.3		
Op. Training & Supervision	1,031.5		
Admin.	667.8		
PHCD	710.2		
Total	2,717.8 ^{c/}		
Vehicles (25)		1,071.0	5,355.0
Equipment		?	?
Furniture		?	?
Vehicle Maintenance	2,500.0		
Supplies	?		
Building Maintenance	81.0		
Per Diems ^{b/}	550.0		
Total	5,848.8(?)	1,071.0(?)	

^{a/} Staffing pattern except for president and deputy president is increased by 50 percent to handle increase to 300 BHC's.

^{b/} Based on 20 percent of salaries, the same ratio is in BHC's.

^{c/} Excludes 25% fringe.

One of the Phase II project outputs will be to establish the actual financial costs of a BHS system patterned after the Girishk regional model. The following analysis is a fairly rough estimate of recurrent budget requirement of a nationwide BHS system. The figures are not to be considered hard data but should be sufficiently reasonable to establish the financial feasibility of the system.

The costs are estimated for four levels of the BHS, the Dai/VHW program, the operations of the BHC's, the operations of the Regional Training Centers and the operating costs of the Department of BHS of the Central Ministry of Public Health.

The total yearly operating budget (including depreciation) for a BHC is estimated to be Afs. 1.52 million at current prices (see B.4.). Excluding depreciation, the recurrent figure is approximately Afs. 1.34 million. Of this it is estimated that Afs. .55 million would be returned in the form of drug payments by the populace. Thus, net recurrent outlays will be about Afs. .79 million per BHC.

The major costs associated with the VHW/Dai programs are the continuing education costs, replacement training costs and equipment/supplies replacement (see B.5.). Total recurrent costs (including depreciation) are estimated to be Afs. 83,000 per BHC. Excluding depreciation, recurrent costs will be Afs. 68,000 per BHC.

Total recurrent costs (including depreciation) of the Girishk Regional Training Center will amount to Afs. 2.09 million per year (see B.6.). If depreciation is excluded this total is reduced to Afs. 2.63 million.

Finally, total recurrent budget of the Department of BHS of the MOPII, given current staffing patterns, are Afs. 6.92 million excluding depreciation for everything except vehicles (see B.7.). Excluding vehicle depreciation leaves a recurrent budget requirement of Afs. 5.85 million.

The total recurrent cost of this four-tiered system depends on the number of units comprising the system at each level. For nationwide coverage of the type to be established in Girishk region there should be 250-300 BHCs and associated VHW/Dai units in place. There will be six Regional Training Centers and, of course one central BHS Department of the Central Ministry. The total recurrent costs excluding depreciation are summarized in B.8.

1/ Supervision costs are included in the BHC.

TABLE B.8

Summary Recurrent Costs
(excluding depreciation) of BHS System

(afs millions, 1978 prices)

	<u>No. of Units</u>	<u>Cost</u>	<u>Cost (including all drugs)</u>
BHS Dept.	1	5.8	5.8
RTC	6	15.8	15.8
BHC's	300	236.3	401.3
VHW/Dai	300	20.4	20.4
Total Cost (1)		278.3	443.3
Total Cost (2) ^{a/}		306.2	471.2

At the current planned rate of BHC expansion, a network of 300 BHC's will be in place in 1990/91. The 1978/79 recurrent budget for BHS is Afs. 68.3 million. To have a net recurrent budget of Afs. 306.2 million (drugs are sold) by 1990/91 will require a budgetary growth rate of 13.3 percent per year in real terms.

No good price index exists for measuring inflationary impact on the MOPH budget, but the consumer goods price index rose by an annual average rate of 5.3 percent per annum for 1968/69 to 1975/76. Using this estimate a rate of growth for the BHS budget of 13.3 percent per annum in current terms would be necessary to finance a nationwide BHS system by 1990/91.

^{a/} With allowance for two percent per year increase in real salaries to 1989/90.

In order to examine the reasonableness of this requirement, the growth rate of the ordinary budget for the entire MOPH must be calculated. If one assumes that the real ordinary budget (excluding BHS) of the MOPH doubles by 1980/90, an implied real growth rate of six percent p.a., the total MOPH ordinary budget in constant 1978/79 prices would become Afs. 880.6 million in 1990/91. This implies a real growth rate of 7.9 percent per annum for the next 12 years in constant terms or of 13.6 percent per annum in current terms. Over the period 1973/74 to 1978/79 the ordinary budget of the MOPH grew by 12.1 percent in current terms. Thus, the GOA will have to increase its rate of allocation to the MOPH ordinary budget by only 1.3 percent per year to finance the expanded BHS system. In 1978/79 the BHS ordinary budget increased from 17.4 percent to 19.3 percent of the total MOPH ordinary budget. By 1990/91 this will have been increased to 35 percent given the assumptions made above.

If no drug sales are made the recurrent budget requirement for BHS becomes Afs. 471.2 million a real increase of 17.5 percent per year or a current growth rate of 23.7 percent per year. The implication in current terms is that the overall MOPH recurrent budget will have to increase by 15.2 percent p.a. and that the share allocated to BHS would increase to 45 percent.

At this preliminary stage, the recurrent costs of the BHS system are considered to be financially feasible. However, this is so under the assumption that BHS will receive increasing priority in budgetary allocations. While the cost estimates without drug sales do not render the financial viability of the project beyond the realm of possibility, not selling drugs does create a significantly greater financial burden on the MOPH and will require an even greater relative commitment of MOPH resources to BHS.

2. Financial Plan

The total cost of the project is estimated at \$17,270,913 of which \$13,983,816 is planned for U.S. assistance (see Table C-1) and \$3,287,097 equivalent is the GOA contribution (see Table C-2). The project will be funded in increments over a three-year period (FY 1978 to FY 1980) with implementation and expenditures covering a three-year period beginning early FY 1979 through FY 1981. A combined inflation/contingency factor of 5 percent in FY 1979, 10 percent in FY 1980 and 15 percent in FY 1981 was added to individual line items. U.S. dollar project inputs follows:

	<u>(\$000)</u>
Long Term Advisors (360 months)	3,433
Consultants (145 months)	1,636
Participants (507 months)	1,071
Commodities	1,372
Construction	3,417
Contract Support Costs	2,104
Local Costs	951
	<hr/>
Total	<u>13,984</u>

Project obligation and expenditure plans by fiscal year are contained in Tables C-3 and C-1 respectively. Initial funding is limited to contract start up costs, commodity procurement, continued construction of the initial 12 Basic Health Centers and the first wave of participants. A detailed list of commodities is included in Table C-4.

GOA contribution to the project includes additional operating cost of the 50 new Basic Health Centers, and four new Regional Training Centers. See Tables C-5 and C-6 for details of the operating costs. Additionally, under fixed Amount Reimbursement procedures the GOA will contribute 25 percent of the estimated construction cost of the 50 new Basic Health Centers and will contribute the land where these centers will be located. This represents 19 percent of total project costs, somewhat less than the 25 percent required under Section 110 (a) of the FAA. Considering the substantial portion of the Phase II project for technical assistance in the experimental/research phase, it is recommended that a waiver of this cost-sharing requirement be approved. Note that Afghanistan is also an RLDC.

Expenditure Plan

<u>I N P U T</u>	<u>FY- 79</u>	<u>FY - 80</u>	<u>FY - 81</u>	<u>T O T A L</u>
<u>Technical Assistance</u>				
Long Term	1,323,095	1,165,098	944,530	3,432,723
Short Term	562,390	623,150	450,110	1,635,640
Professional Local Contract Staff	77,400	81,086	84,771	243,257
Home Office Expense	228,008	202,345	250,413	680,766
<u>Sub-Total Technical Assist.</u>	<u>\$2,190,883</u>	<u>\$2,071,679</u>	<u>\$1,729,824</u>	<u>\$5,992,386</u>
<u>Participant Training</u>				
U.S. Short Term	174,150	383,550	363,525	921,225
Third Country Short Term	63,000	53,900	33,350	150,250
<u>Sub-Total Part. Training</u>	<u>\$237,150</u>	<u>\$437,450</u>	<u>\$396,875</u>	<u>\$1,071,475</u>
<u>Project Commodities</u>				
Vehicles	73,777			73,777
Drug Revolving Fund	475,000	275,000		750,000
Other	309,271			309,271
Supplies HVP	59,184	81,496	97,942	238,622
<u>Sub-Total Proj. Commodities</u>	<u>\$917,232</u>	<u>\$356,496</u>	<u>\$97,942</u>	<u>\$1,371,670</u>
<u>Construction</u>				
First 12 BHC's	181,865	90,000		271,865
Second 38 BHC's	528,000	1,026,000	1,384,500	2,938,500
Supervision	9,990	9,429		19,419
Equipment	29,400			29,400
Drug Storage Facility	121,550	36,000		157,550
<u>Sub-Total Construction</u>	<u>\$870,805</u>	<u>\$1,161,429</u>	<u>\$1,384,500</u>	<u>\$3,416,734</u>

	<u>FY -79</u>	<u>FY -80</u>	<u>FY-81</u>	<u>T O T A L</u>
<u>Contractor Support Costs</u>				
Vehicles	30,806	23,527		54,333
Equipment & Supplies	133,972	72,085	61,562	267,619
Support Staff	140,500	147,190	153,881	441,571
Other	150,255	142,447	124,070	416,772
<hr/>				
Sub-total Contractor Support Costs -----	\$455,533	\$385,249	\$339,513	\$1,180,295
<hr/>				
<u>Project Local Costs</u>				
Training Support Costs (National)	44,185	42,095	41,077	127,357
Training Support Costs (Grishk)	67,073	72,790	86,514	226,377
Community Based Distribution	107,000	110,000	133,000	350,000
Other	70,050	79,174	98,293	247,522
<hr/>				
Sub-Total Proj. Local Costs -----	288,308	304,059	358,889	951,256
<hr/>				
<u>T O T A L</u>	\$4,959,911	\$4,716,362	\$4,307,543	\$13,983,816

C-2

G O A
Inputs

	Amount in <u>\$</u>
Operating Cost of New BHC's (see Annex	2,016,506
25% of Construction Cost Under FAR	802,591
Land for Centers \$2,000 X 50	100,000
Regional Training Centers (see Annex	368,000
	<u> </u>
<u>T o t a l</u>	<u>3,287,097</u>

Obligation Plan
(\$ 000)

	<u>FY-78</u>	<u>FY-79</u>	<u>FY-80</u>	<u>T o t a l</u>
<u>Technical Assistance</u>				
Long Term	631	1,165	1,637	3,433
Short Term	100	460	1,076	1,636
Professional Local Staff	38	120	85	243
Home Office Expense	195	236	250	681
<u>Sub-Total Tech. Assist.</u>	<u>964</u>	<u>1,931</u>	<u>3,048</u>	<u>5,993</u>
<u>Participant Training</u>				
US Short Term	174	184	563	921
Third Country Short Term	63	54	33	150
<u>Sub-Total Part. Training</u>	<u>237</u>	<u>238</u>	<u>596</u>	<u>1,071</u>
<u>Project Commodities</u>				
Vehicles	74			74
Drug Revolving Fund	475	275		750
Other	309			309
Supplies for HVP	30	111	98	239
<u>Sub-Total Proj. Commodities</u>	<u>888</u>	<u>386</u>	<u>98</u>	<u>1,372</u>
<u>Construction</u>				
First 12 BHC's	182	90		272
Second 38 BHC's		1,554	1,385	2,939
Supervision	10	9		19
Equipment	29			29
Drug Storage Facilities		158		158
<u>Sub-Total Construction</u>	<u>221</u>	<u>1,811</u>	<u>1,385</u>	<u>3,417</u>
<u>Contractor Support Costs</u>				
Vehicles	31	24		55
Equipment & Supplies	134	72	62	268
Support Staff	141	147	154	442
Other	150	142	124	416
<u>Sub-Total Contractor Support Costs</u>	<u>456</u>	<u>385</u>	<u>340</u>	<u>1,181</u>
<u>Project Local Costs</u>				
Training Support (National)	13	91	23	127
Training Support (Grishk)	21	131	74	226
Community Based Distribution		217	133	350
Other		149	98	247
<u>Sub-Total Proj. Local Costs</u>	<u>34</u>	<u>588</u>	<u>328</u>	<u>950</u>
<u>T O T A L</u>	<u>2,929</u>	<u>5,389</u>	<u>5,795</u>	<u>13,993</u>

C o m m o d i t i e s

<u>I t e m</u>	<u>A m o u n t</u> <u>in \$ 000</u>
Pharmaceuticals	750
Warehouse & Packing Equipment	143
Drug Cabinets (375)	53
Office Equipment	9
Injection/First Aid Kits	12
Flip Books/Posters	23
Bicycles (350)	33
2 Wheel drive Vehicles (2)	17
4 Wheel drive Vehicles (5)	57
Filing Cabinets/Schedule Books	5
Calculators/Typewriters	13
Motorcycles (25)	18
Home visiting supplies	238
	<hr/>
<u>T o t a l</u>	<u>1,371</u>

G O A
Operating Costs of BHC's

Cost of Operating an average BHC per year	Amount in <u>(Afs.)</u>
Staff Salaries	385,000
Vehicle Operating Costs	110,000
Maintenance/Supplies	60,000
Drugs	250,000
Oral Rehydration	37,680
Replacement of injection/ First Aid Kits	68,000
	<hr/>
T o t a l	910,680
	<hr/> <hr/>

- (1) In year one 18 BHCs will be completed.
Assuming $\frac{1}{2}$ will be operational for the
year.

$$18 \div 2 \times 910,680 = 8,196,120$$

- (2) In year two 32 new BHCs will open.
Assuming $\frac{1}{2}$ will be operational for
the year.

$$(32 \div 2) + 18 = 34 \times 910,680 = 30,963,120$$

- (3) In year three all 50 will be operational.

$$50 \times 910,680 = 45,534,000$$

T o t a l	Afs. P4,693,240
<hr/> <hr/>	<hr/> <hr/>

Dollar Equivalent

Afs. 42 = \$1.00 \$2,016,506

G O A
Operating Costs RTC's

Costs of Operating An Average RTC
per year

Salaries	1,560,000
Vehicle Operating Costs	300,000
Supplies & Maintenance	72,000

<u>T o t a l</u>	<u>1,932,000</u>

- (1) In year one assume two centers will be operational $\frac{1}{2}$ time. $2 \times \frac{1}{2} = 1 \times 1,932,000 = 1,932,000$
- (2) In year two assume two centers will be operational $\frac{1}{2}$ time and the two centers opened last year fully operational.
 $2 + (\frac{1}{2} \times 2) \times 1,932,000 = 3,796,000$
- (3) In year three all centers open and fully operational. $4 \times 1,932,000 = 7,728,000$

<u>Total</u>	<u>Afs.15,456,000</u>
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Dollar Equivalent at Afs.42:-\$1.00 = 368,000

C. Economic Analysis

The impact of a project aimed at improving the health status of a population, while important in quality-of-life terms, is almost impossible to measure in economic terms. This is a fortiori the case when trying to estimate the anticipated impact. Thus, no attempt at a benefit/cost analysis is made.

1. Beneficiaries

The direct beneficiaries of the project will be: (1) the 75 percent of the population of Girishk region for whom improved health services will be available; (2) the rural population who currently have access to BHS and for whom the quality of services will be indirectly improved through better central management; (3) ultimately, the 75 percent of the rural population of Afghanistan for whom improved health services will become available if the BHS system is replicated nationwide; (4) the health personnel whose skills are upgraded and whose income earning capacity is thereby enhanced.

It is estimated that the establishment of 50 new BHC's will provide access to health care directly to 750,000 rural people, 135,000 of whom live in Girishk region. In addition, approximately 600,000 rural people in Girishk region will have access to the BHS system through the AHDS. By 1990 an increase in nationwide BHS coverage from the current 15 percent to 75 percent of the rural population, would mean that 9.5 million more people would have access to the BHS system. As noted in the Social Analysis the people benefitting most will be that part of the population now excluded from health care because of income constraints.

2. Anticipated Impact

As noted at the outset, the total anticipated impact of this project cannot be measured either qualitatively or quantitatively. One measurable component, and an important one from a long range development view, is the impact of the project on population growth rates. According to SUNY data the natural rate of increase of the population of Girishk region in 1973 was 1.9 percent. By 1985, it is anticipated that there will be a reduction in child mortality of 25 percent. At the same time it is anticipated that 15 percent of the fertile population will be continuing contraceptors. Using assumptions contained in Table D.1 and neglecting demographic changes occurring prior to 1985, such changes in fertility/mortality would reduce the natural rate of increase in the population of Girishk region to 1.7 percent. If such goal targets can be achieved they will have the remarkable effect of eliminating the period of very rapid population growth associated with early stages of the demographic transition of a population. Perhaps the greatest medium-to-long term threat to basic economic development in Afghanistan will thus have been averted. Even if the fertility assumptions prove to be

optimistic, the attention paid to the family planning component of the Basic Health system will help to ensure that the lag between mortality reduction and fertility reduction will be reduced.

One of the major indicators of quality of life of a population is its life expectancy. Currently it is estimated that the life expectancy of the population of Girishk region is 36 years of age. A 25 percent reduction in infant mortality will have the effect of raising life expectancy to 41 years.^{1/} This assumes that no other impact on mortality occurs. Since better health services would clearly have some impact on mortality other than infant mortality, if project goals are met the life expectancy in the region would increase by more than five years by 1985.

^{1/} This is an approximation of increased life expectancy. The population figures were not converted to coincide with a stable population.

C.1

Demographic Data for 4 Provinces of
Nimroz, Farah, Kandahar, and Helmand

	<u>1973</u>	<u>1985(without)</u>	<u>1985(with)</u>
Total Population (sedentary)	1,219,358	1,520,736	1,518,171
Total Number of Live Births	15,685	64,460	55,984
Growth per 1000 of population	29,447	36,735	30,814
Total births by mothers age 15-29	32,261	40,235	36,211 ^{1/}
Total births by mothers age 30-44	17,845	22,256	17,804 ^{1/}
Total births by mothers of other ages	1,579	1,969	1,969
Number of deaths children age 0-4	18,960	23,646	17,735 ^{2/}
Number of deaths other ages	10,487	13,079	13,079

^{1/} 10 percent decline in births by mothers of age 15-29 and 20 percent decline in births by mothers of age 30-44.

^{2/} 25 percent decline in child mortality of that age group.

3. Economic Costs

This section attempts to obtain a rough idea of the economic costs of the project. Costs are estimated using empirical costs and with foreign exchange shadow priced. The summary table with all foreign assistance included is shown below:

	<u>Economic Costs</u> <u>(\$ millions)</u>
A. Empirical Values	
Undiscounted	40.7
Discounted at 15 percent	15.2
B. Fix Shadow Priced	
Undiscounted	45.6
Discounted at 15 percent	17.2

In calculating the economic costs of the project, the costs of training of medical personnel, with the exception of VHWs and Dais, were excluded. It was assumed that the output of such personnel is independent of the project. It was further assumed that relative prices will be constant and that if the foreign assistance did not go to this project, it would be available to another project. The social cost of capital was assumed to be in the neighborhood of 15 percent. It was also assumed that wages did not need to be shadow priced. Skilled labor presumably should be priced higher than is actually being paid and unskilled lower. On the average the aggregate wage bill may be as good a figure as could be used given the information needed to compute accounting prices for labor. The Foreign Exchange rate was adjusted by 25 percent. This follows from calculations made for other projects.^{1/}

The cost of the system per client-visit, which is often used as an economic measure is difficult to calculate and an ambiguous measure in this project. There are factors arising from the project which will tend to increase BHC usage and also factors which will tend to decrease usage. The better the preventive/outreach aspect of the project works, the higher will be the per-client costs. Moreover, the costs of the project include construction activities, central management support, and an in-depth experiment. The appropriate number of client visits (only for 50 centers (?), for all BHCs (?), etc) to be included in the numerator and the appropriate costs to be included in the denominator are not

^{1/} It is not clear that shadow pricing is appropriate given Afghanistan's present international financial position, its relatively free money market and its apparent inability to mobilize these resources.

immediately evident. For both of these reasons no attempt was made to measure per client visit costs.

Suffice it to say that in 30 years the rural population of Afghanistan could be 21.7 million. With a 75 percent coverage rate 16.3 million rural people would have access to health care. Under the current 15 percent coverage rate only 3.3 million people would have access. Thus, 13 million more people could have access to BHS in 30 years as a result of this project. By 1990 when the system is in place, 9.1 million additional rural people will have access to BHS and a total 11.4 million rural people will be receiving better health care through the BHS system. Thus, the extraordinary economic development costs (technical assistance, consultant cost) are on the order of fifty cents per potential beneficiary. The operating costs of the system by 1990 will be approximately sixty cents per person covered per year. These estimates indicate that the health services will be delivered at a relatively low cost.

TABLE D-2

Economic Costs (undiscounted) of Building and Operating Project Health Delivery System
(\$ 1000)

Year	Construction ^{a/}	Contingency ^{b/}	Technical Assistance	Particip. Training	Project Commodities ^{c/}	Cont. Support Cost	Proj Local Costs	Personnel	Supplies & Maintenance ^{d/}	Total
1.	1,055	106	2,086	226	874	434	274	-	-	5,055
2.	1,394	139	1,883	398	324	350	276	-	-	4,764
3.	1,605	160	1,504	345	85	295	312	110	120	4,536
4.	↓	↓	↓	↓	-	↓	↓	458	500	958
5.	↓	↓	↓	↓	35	↓	↓	↓	↓	993
6.	↓	↓	↓	↓	↓	↓	↓	↓	↓	953
10.	↓	↓	↓	↓	35	↓	↓	↓	↓	993
11.	↓	↓	↓	↓	↓	↓	↓	↓	↓	953
15.	↓	↓	↓	↓	330	↓	↓	↓	↓	1,283
16.	↓	↓	↓	↓	↓	↓	↓	↓	↓	953
20.	↓	↓	↓	↓	35	↓	↓	↓	↓	993
21.	↓	↓	↓	↓	↓	↓	↓	↓	↓	953
25.	↓	↓	↓	↓	35	↓	↓	↓	↓	993
26.	↓	↓	↓	↓	↓	↓	↓	↓	↓	958
30.	↓	↓	↓	↓	↓	↓	↓	458	500	953
Totals	4,054	405	5,473	969	1,753	1,079	862	12,476	13,620	40,691

a/ Total construction costs.

b/ 10% contingency for construction.

c/ Includes 7 vehicles to be purchased every 5 years for \$10,000 per vehicle in year one and \$5,000 per vehicle in other five year intervals. In year 15 an additional \$295,000 is required for commodities.

d/ Includes Afs. 250,000 per BHC per year for drugs.

Exchange Rate used Afs. 42.00 = U.S. \$1.00

Effect of Shadow Pricing the Foreign Exchange Component
of Project Economic Cost Flow
(\$ 000)

<u>Year</u>	<u>Total Cost FX not Shadow Priced</u>	<u>FX Component of Total Cost</u>	<u>FX Component Shadow Priced (25% higher)</u>	<u>Total Cost with FX Shadow Priced</u>
1	5,055	3,214	4,018	5,353
2	4,764	2,781	3,476	5,460
3	4,536	2,317	2,896	5,115
4	958	400	500	1,053
5	993	435	544	1,102
6	958	400	500	1,058
.	↓	↓	↓	↓
.	↓	↓	↓	↓
10	993	435	544	1,102
11	958	400	500	1,053
.	↓	↓	↓	↓
.	↓	↓	↓	↓
15	1,288	629	786	1,445
16	958	400	500	1,053
.	↓	↓	↓	↓
.	↓	↓	↓	↓
20	993	435	544	1,102
21	958	400	500	1,058
.	↓	↓	↓	↓
.	↓	↓	↓	↓
25	993	435	544	1,102
26	958	400	500	1,058
.	↓	↓	↓	↓
.	↓	↓	↓	↓
30	958	400	500	1,058
TOTAL	40,691	19,481	24,352	45,562

D. Socio-Cultural Analysis

Afghanistan's Sirishk Region, the geographic focus of the Phase II experiment comprises four large southern provinces (Kandahar, Helmand, Nimroz and Farah). The total population of the region is about 1.2 million, 85 percent of whom are rural inhabitants. Most of the rural people are employed in agriculture, mainly irrigated winter wheat and, if dryseason irrigation water is available, cotton and corn. Due to the dependence upon irrigation for agriculture, most communities are found either along the major water courses (the Helmand and Argandab Rivers and their tributaries) or in the northern foothills where streams springs, or Karez systems can support small-scale agriculture. Population densities are low (less than 10 people per km.²), and of the 2900 villages in the region, 2300 have populations less than 500.

The region's population is ethnically diverse. Pushtuns comprise the majority but Baluch and Tadjiks are also found in significant numbers. Super-imposed on these indigenous peoples are some 15,000 families, representing every geographic location and ethnic group in the country, who have been settled by the Government in the Helmand River Valley. Despite the region's ethnic diversity the social structure and belief system of the people are remarkably homogeneous (for good, brief descriptions of the region and the culture, see Barth 1965, 1969; Scott 1971; and the social analyses contained in the Helmand Drainage Project Phase II and the Integrated Wheat Development Project Papers).

1. Health Care

A number of accessible, well-written descriptions of Health Care in Afghanistan exist. Rather than attempt to summarize this data, a paper by Pillsbury is included as an appendix to this Project paper. Those interested in more information should consult the bibliography in the Pillsbury paper. The remainder of this section assumes that the reader is familiar with the USAID Health Sector Assessment (March 1978) the attached Pillsbury paper, and the Three Province Health Survey of Afghanistan published by Management Service for Health (July 1977).

2. Beneficiaries and Social Cultural Adaptability

a. Beneficiaries

The major beneficiaries of the Phase II project are the people living in rural areas who currently do not have access to an effective, relevant, health delivery system. Although all segments of the rural population will benefit, mothers and children will receive greater attention and hence larger benefits since in the past this group has been the most deprived. In terms of socio-economic class,

however, the poorer rural families should receive the bulk of the project's benefits (i.e., their overall health status should manifest the greatest relative improvement). The poor have the highest disease, mortality, and fertility rates and have the least knowledge of good health and family planning practices. Since the Phase II project is focused on treating and/or preventing the most serious illnesses and health problems in the village, and advising on family planning, it will have the greatest impact on lower socio-economic groups.

The 650 Dais who will be provided training and instruction to upgrade their midwifery skills will also be beneficiaries under this project. In addition, they will be given training in child spacing techniques and in identifying birth complications, malnutrition in children, and other health problems of women and children. The acquisition of improved midwifery and other skills will enhance the status and role performance of the Dai and make them more effective participants in the rural health delivery system.

A considerable amount of new employment will be generated in this project. There are some 350 VHWs who will be recruited and trained for the Girishk Region; their income will be derived from the selling of drugs obtained from the BHC. Mobile training team personnel, ANMs and sanitation workers at the BHCs, and a number of central Ministry people will also receive employment through this project. In addition, approximately 160 MOPH personnel will receive direct training under the project's short-term participantships, while the entire management staff of the MOPH will receive on-the-job training.

b. Adaptability

One of the major problems of introducing change into a rural area is the acceptance by the local community of the change agent. It normally takes several months for an outsider to win the confidence of the villagers, which is prerequisite to introducing the desired changes. Moreover, it is often the case that once the change agent has left the area the villagers revert to their old ways. The Phase II project largely avoids both of these problems. The Dai whose skills will be upgraded and expanded is already a functioning practitioner in the indigenous health system. The new skills she will apply within the community are not radically different from her traditional practices. She will not only be accepted by the community, but her status and potential as a change agent will increase commensurately with her effectiveness.

Similarly, the VHM will not find acceptance by the villagers to be a major problem, since he too will be selected from the village in

which he will be practicing. His acceptance as a VHW will depend entirely upon his effectiveness in treating and preventing disease and illness within the community. His effectiveness, unlike the Dais, is as yet unproven. The VHW's training, which is focused on identifying and treating a limited number of the most serious diseases and illnesses affecting the rural areas, will assist him in quickly gaining that acceptance.

As noted, there are essentially two types of medical systems operating in Afghanistan. One is the indigenous system and the other is the national, urban-based, western-oriented system. One area of concern is the relationship between these two systems, both presently and during the Phase II project period.

Investigation has shown that the majority of the rural population currently uses both the traditional and the 'modern' system for health services. The two systems are not in competition but rather complement each other, each providing its own distinct advantages in terms of cost, access, psychological comfort, etc. The Phase II project will not threaten this "symbiotic" relationship. On the contrary, it is attempting to improve the role performance of practitioners in each system.

Although the major features of the project design and the socio-cultural system are in harmony, there are likely to be some difficulties changing certain village health practices. For example, the MSH survey found that many villagers do not recognize the same etiological agents that western-oriented, urban-trained health personnel recognize. Malnutrition, for instance, is not viewed as contributing to illness and poor health. Thus, it will be very difficult to change dietary practices. Similar difficulties will be encountered when Dai and VHW attempt to change child rearing practices (e.g. the earlier introduction of solid foods into the infant's diets). Likewise, it will be difficult to get people to stop drinking impure water directly from the well when they clearly prefer the "taste" of moving water over well water or boiled water. These cultural practices are important to consider when planning certain features of the project design.

3. Spread Effects

The Phase II project will have spread effects at three different levels: within given villages, in the Girishk Region, and in other regions of Afghanistan.

a. The Village

The population of a given village can be divided, for analytical purposes, into three groups: those using the national health

system as a supplement to the indigenous health system, those using the national system as a last resort, and those who rely almost exclusively upon the indigenous system. The aim of this project is to move the majority of the rural population into the first category. This can be done only by demonstrating explicitly that the national health system is effective in delivering relevant health services. The MSH Three Province Survey found that the health problems perceived by the villagers themselves account for the majority of illnesses. Further, it was found that there are actually a relatively small number of illnesses, many preventable or treatable at the village level, which account for the major portion of illnesses and deaths. It follows that to the extent Dais and VHWs are successful in preventing and treating major illnesses at the village level, the villagers will perceive them as effective agents against disease and illness. Their services will be sought and their status in the village will rise. As their effectiveness becomes more evident and their reputation spreads, villagers who previously have not used the national health system will begin to seek the latter's services as either a major supplement to the services provided by the indigenous system or, less desirably, as a last resort after the indigenous system has proven ineffectual for a particular disease or ailment.

b. The Girishk Region

The success of the Phase II project will depend upon the performance of some 350 VHWs and 650 Dais. It would be extremely difficult and costly within the short term to provide a trained Dai and VHW for each village. The original 350 VHWs will work in some of the larger villages, and early expansion will occur mainly in these larger population centers. It is envisioned that small contiguous villages will have to share a trained Dai or VHW if the program is to remain economical. This should not pose a problem since small villages already share the services of Dais, mullahs, barbers, teachers, and others.

c. Other Regions in Afghanistan

The best Dai, VHW, or Basic Health Center would not long remain effective in their expanded roles if they did not have a national system based in Kabul to support them. Medicine and other supplies are needed in a timely manner; training and refresher courses must be administered; salaries, promotions, and transfers must be under the auspices of an efficient personnel system; and the referral system from Dai and VHW up through the BHC and to the provincial and national hospitals, must be responsive. An important assumption in this project is that if the delivery of health services in rural Girishk is successful, then the support system is operating at an acceptable level of efficiency, i.e., that it indeed is capable of supporting at least one regional program.

Based upon experience gained in the Phase I project, the national support system will be improved and expanded such that it can support other regional programs. The ultimate goal is to cover the entire country with an effective basic health delivery system (see Economic Analysis). It is assumed that a national support system designed to support at least one regional program will need proportionately less expansion each time a new region is added. There is, as it were, an economy of scale involved in expanding this program on a national level.

Although the program will obviously have to be sensitive to inter-regional social and cultural variations, all anthropological evidence at hand suggests that these differences and variations will not significantly inhibit a nation-wide expansion of the program.

4. Distribution of Benefits - Social Impact

There is currently differential access to health and family planning services. Wealthier families can more easily afford to pay for medicines and services that are available in or near their village, or, if required, they can afford to make the trip to an urban center for medical treatment. To a large extent, it is the wealthier strata of the rural population which is utilizing the urban-based, national health system. The poor are more or less precluded financially from this system and thus are forced to depend more upon indigenous practitioners and medications.

This program will expand the network of BHC's, place VHW's in some 350 villages, and improve the skills of several hundred indigenous midwives. To the extent that these services are physically more accessible to all villagers, the delivery system will have potential benefits for all. In relative terms, the poor, because they did not have access to these services previously, will benefit more than the richer families, who have always had some access to national health services. On the other hand, the richer families will probably benefit more in absolute terms, at least in the short run, since they are already predisposed to accepting modern drugs and practices.

Solely in terms of drugs, poorer families should also benefit relatively more than richer families. Current studies show that seven percent of the average rural family's income is spent on health care, and of this nearly 40 percent goes for drugs. These are average figures, however, and it is likely that poorer families spend very little, or even nothing, on packaged drugs. Under this project, access to free or inexpensive drugs for the poor will be greatly expanded. First, VHWs will not only bring packaged drugs into the village but will be selling them at a price much lower than that charged by local pharmacies. (The VHW will sell drugs

at a price equivalent to cost plus profit, and this may be from 70 to 80 percent lower than prices elsewhere). Secondly, the BHCs will continue to distribute some drugs free of charge. To the extent that more BHCs are constructed, and they become more efficient and can thus attract a larger clientele, more needy families will benefit from these free distributions of drugs.

For the most part, the project will not threaten the livelihood or power position of any rural villagers. It is possible, however, that some local practitioners may discover that their clientele has become reduced. For example, the services of hakims, bonesetters, mullahs, and others will not be as eagerly sought after in the future if the Dai, VHW, ANM, home visitors, and others prove efficacious. Because the Dai and VHW are recruited from the village in which they will work, however, it is not likely that the former indigenous personnel will attempt to thwart the project. Nevertheless, DAI and VHW's will be carefully selected to insure that they have the commitment and support of the majority of villagers.

The Phase II project relies heavily upon the Dai and the VHW to undertake tasks for which there will be relatively little remuneration; in some cases, there is no incentive whatsoever for the performance of these tasks. For example, the Dai is expected to monitor the health and nutritional status of children within the village and to refer these cases to the BHC. This is an extra-midwifery service for which she will not be compensated. Further, the Dai is expected to provide counselling and family planning services to village women. There is not only no incentive or compensation for this, but in so doing the Dai may be reducing her major source of income, delivering babies. The VHW is also asked to involve himself in activities beyond his ken of disease diagnosis and drug disbursement, his only source of income. He is expected to advise on a number of environmental health problems such as water purity, waste disposal, the cleanliness of the home, and personal hygiene. Like the Dai, the VHW will receive no compensation for these extra-duties, and he too may perceive a disincentive in performing them. These problem areas will have to be carefully monitored during the course of the project, and various incentive systems will have to be tested. One possibility is to use BHC drug sale profits to support village-level programs. Again the income generating aspects of the Phase II project cannot be overemphasized.

5. Women in Development

In Afghanistan it is culturally unacceptable for a male physician or health worker to examine a woman, and yet the number of trained and accessible female health personnel in the rural areas is extremely small. Consequently, rural women have been deprived of health services, which is reflected in their higher morbidity and mortality rates and in turn has an influence on infant mortality. This project, by expanding the availability

of female medical staff in the BHCs and in the villages, will attempt to ameliorate this discriminatory situation.

At each BHC there will be at least a female MCH worker who can attend to the minor health needs of female patients. Most importantly, this worker can serve as an intermediary between the female patient and the male physician. In the past, no female health personnel were present in the BHC, and female patients could not have even indirect access to a physician. Ideally, of course, both a male and a female physician would be present in the BHC. Until such time, however, the problem of direct access of women to physicians remains.

At the village level, women will have access to Dai. These Dai will be trained to conduct normal deliveries safely and to recognize high-risk pregnancies which will be referred to the BHC or provincial hospital. The Dai will also be taught preventive educative care for the pre-natal, delivery, and post-natal periods. This Dai training should contribute significantly to the reduction of female mortality associated with childbirth (the maternal mortality rate in Afghanistan is currently around 642 per 100,000 births, which is one of the highest rates in the world).

The Dai will also be taught to recognize numerous health problems in children, and she will be involved in educating the community about such things as malnutrition, treatment of diarrhea, child feeding, etc. All of these activities should impact positively on the health status of children, if not in fact contribute to the reduction of infant mortality.

The reduction of both female and infant mortality will, in the short run, lead to a small increase in the birth rate. In the long run, however, particularly as the Family Planning Program gains momentum and acceptance, this increase in the birth rate will subside and eventually the overall birth rate should actually decrease. Both the Dai and the VHW will be educating the community about family planning practices and thus will be instrumental in expanding the dissemination of this program.

A reduction in female mortality and morbidity and a reduction in the number of births per female are prerequisite for expanding the role of women in society. A healthy woman is able to provide better care for her children; when families are smaller, each child receives greater care and attention; and a woman who is able to perform her role as a mother more efficiently--and who is also freed at last from the constant cycle of pregnancy and childbirth--is able to devote more time to extra-household affairs and community-oriented activities.

In the past, only elite women have been able to participate in the wider society. They have usually delayed their marriages (and thus

the beginning of their childbearing) by obtaining higher educations, and they also have greater knowledge of and access to birth control techniques. Even when they have not been able to limit their childbearing, they have had the financial resources to hire servants and nannas to care for their children. In any case, they have been able, more or less, to free themselves from the confines of child raising and housework and to carve out roles for themselves in the larger society. This project cannot, of course, guarantee the same for village women in Girishik, who are poorer and do not have the social connections of the elite. But the task of implementing some of the more important prerequisites for female participation in the wider society (smaller families, healthier women and children, etc.) will have been initiated.

PART IV - IMPLEMENTATION PLANNING

A. Administrative Arrangements

1. Government Administrative Arrangements

a. Ministry of Public Health

The Phase II project will considerably strengthen the capabilities of the Ministry of Public Health through the development of central ministry management systems. In summary, the project aims to develop a management system within the MOPH capable of supporting regional basic health care and then subsequently launching a national basic health care system. At the end of Phase II, management systems will be in place in terms of basic health services, logistics, information and manpower planning.

While the MOPH appears committed to the purposes of the Phase II project, its management structure is currently insufficient to implement a national health care system. The composition of the proposed Management Team is in terms of the Phase II scope and is deemed adequate to meet those requirements. Establishment of a Management Training Unit within the MOPH will go a long way to sustaining the momentum of the Phase I and II for the subsequent Sector effort. It is also agreed that counterparts will be on the job for the duration of the Phase II effort. Long-term training will be deferred to the Sector phase after systems are designed and in place.

b. The Regional Training Center

A principle thrust of the Phase II effort is decentralization of the management structure of health. The Regional Training Center is pivotal to that effort. It is responsible for initiating the village-level program in Girishk, continuing education for that program, initiating continuing education at the BHCs, introducing public health education to the Girishk region, strengthening their supervisory function and training for village and district programs, and finally maintaining material support of the village-level workers and BHCs.

The Phase II project will place two full-time advisors in Girishk as well as the survey analyst for the Baseline Survey. While it could be argued that regional placement could "overload" the system, it is the view of the Project Committee, however, that if decentralization is to work, capacity must be in the region. The capabilities of the Regional Training Center personnel will be considerably strengthened by the training aspects of the project.

c. The Basic Health Center

The Basic Health Center assumes new administrative responsibilities in the test area of Girishk. Responsibility for supervision of village-level programs will be assumed. There are also new facility-based and community outreach preventive programs being added to the BHC agenda. Together they constitute a significant increase in managerial responsibility. While management training will be important, perhaps even more important is the test of the non-physician doctor as BHC manager. The regional proximity of technical advisors is an essential pre-condition to assuring the success of this component of the project.

2. AID Project Administration

The Phase II project is complex both technically and in its geographic scope; therefore, a detailed performance oriented monitoring procedure is planned. The MOPH and Management Team will submit a workplan for USAID approval within three months of mobilization. Working within the project concept described herein, the Management Team will prepare detailed task assignments, schedules, output targets and performance measures. In a sense, the project is a feasibility test for a broader sector effort in FY 1982. That program will be largely determined by progress against targeted performance indicators in the Phase II project.

a. Monitoring

Close Mission monitoring of the Phase II project is crucial. The Mission will have an experienced public health officer in charge of project monitoring. The officer will observe the project, as it is implemented by the Ministry of Public Health and Management Team, to see whether the project is proceeding as planned and in accordance with Government/AID understandings. In doing so, the officer will:

- maintain a continuous liaison with MOPH officials involved in project implementation;
- review material submitted in fulfillment of conditions precedent, including the Management Team workplan, advising the Government and USAID whether progress is adequate and on schedule and what steps should be taken to correct deficiencies;
- review Afghanistan's progress toward performance targets, advising the Government and USAID whether progress is adequate and on schedule and what steps should be taken to correct the deficiencies;

- review all project reports and conduct personal inspections;
- participate in evaluations;
- serve as a technical and managerial advisor to Afghan project implementers on health policy questions, planning, training and other project related issues; and
- maintain liaison with WHO and other donors.

As one aspect of monitoring progress, the Mission will verify completed physical facilities through inspections. For the duration of Phase II, the Mission direct-hire engineering staff will perform this function. A more detailed discussion of facilities construction is found below.

b. Review and Evaluation

Joint reviews will be held semi-annually during the Phase II project period. The purpose of the reviews will be to review progress and problems associated with the project. Performance targets, progress made in reaching them, contractor performance and general project management considerations will be the major focus of the reviews. The agenda for each review will be jointly developed by the Government and USAID. Regional health officers will participate fully in the reviews.

In addition to the review meetings, there will be continuous evaluation of the proposed basic health care system throughout. This evaluation will be directed by a Senior Health Planner to be contracted by AID apart from the Management Team. Thirty-six man-months of consultancy services are provided in the Phase II project for this purpose. It is expected that the Health Planner and Evaluation Officer would spend at least three months of each year in Afghanistan. Eighteen additional man-months are provided for additional specialized expertise. The design of the evaluation program should proceed simultaneously with preparation of the Management Team's workplan. Both will be reviewed by USAID at the same time.

The purpose of the evaluation will be to: (i) assess project performance vis-a-vis the strategy outlined herein and the implementation design included in the workplan, (ii) assess the financial viability and technical feasibility of the proposed basic health care system based on the Girishk Experiment, (iii) assess the capacity of central ministry management systems to launch and sustain a national health care program, and (iv) recommend the feasibility and desirability for the Government

to proceed, and AID to support, national replication. If after the Phase II project and evaluation, USAID decides to proceed to support a national system, a Sector Grant Paper will be submitted to Washington for approval.

c. Reporting

To monitor the project for compliance with conditions, covenants and progress, USAID, in an implementation letter, will present a system for regular reporting. The mission project officer will be responsible for monitoring the reporting system and insuring, to the extent possible, report accuracy.

B. Implementation Arrangements

1. Project Performance Tracking Network

The project tracking network (following) covers selected project indicators which relate to important project output targets (milestones). The network is set against both fiscal and calendar year targets, although it may also be used in terms of project month zero at the point in time when the Government meets conditions precedent.

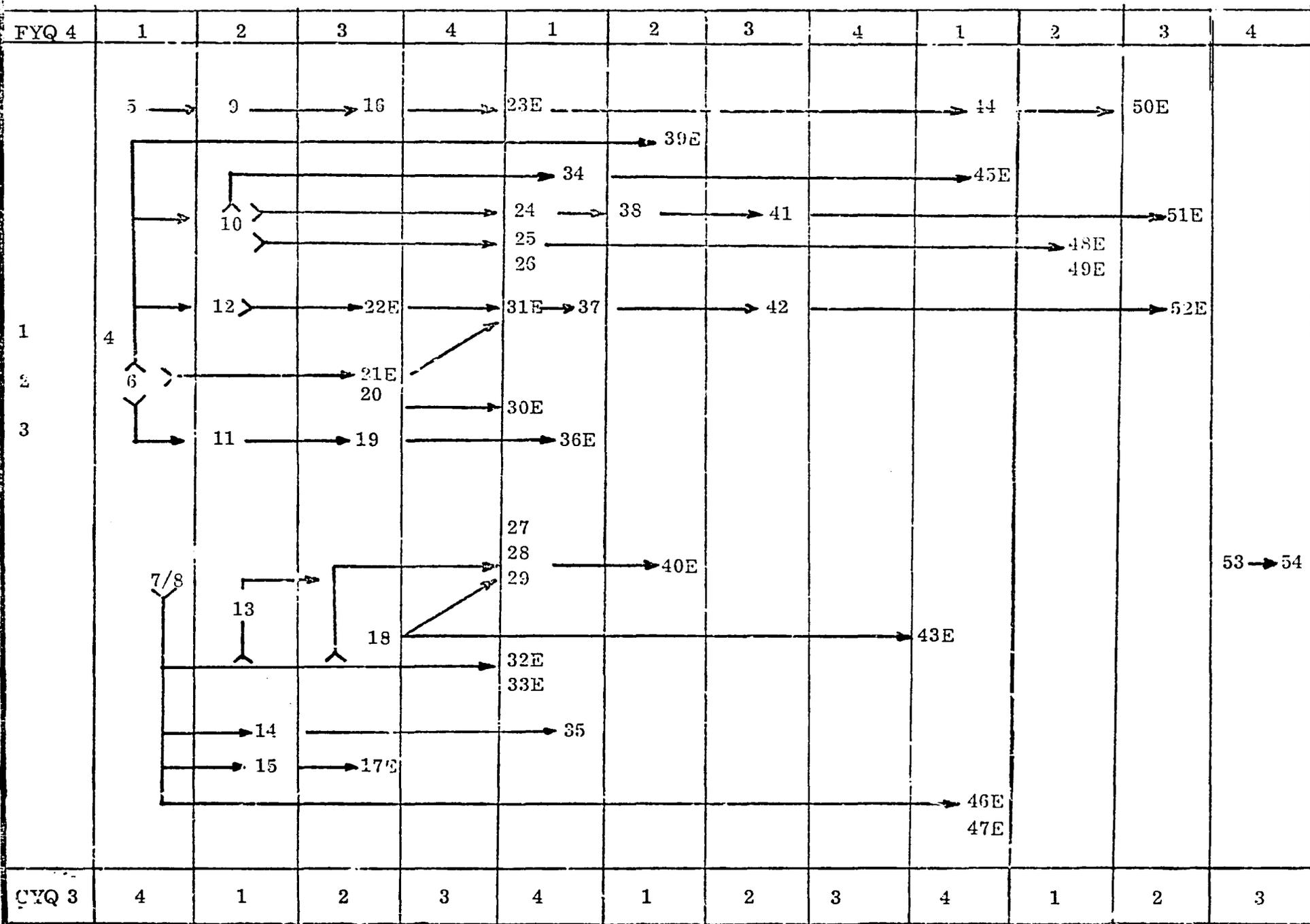
PPT FORM

<u>No.</u>	<u>Project Month</u>	<u>Calendar Month</u>	<u>Milestone</u>	<u>Responsibility</u>
1.		June 78	Project authorization	AID
2.		July 78..	Project Agreement.	USAID/Government
3.		Aug. 78	CPs (including TA contract) approved	Government/AID
4.	1	Oct. 78	Contractor mobilization	Contractor
5.	2	Nov. 78	Baseline Survey design initiated	Contractor
6.	2	Nov. 78	OJT of RTC commenced	Contractor
7.	3	Dec. 78	Contractor workplan submitted	Contractor
8.	3	Dec. 78	Evaluation plan submitted	Health Planner
9.	4	Jan. 79	Baseline design complete	Contractor

<u>No.</u>	<u>Project Month</u>	<u>Calendar Month</u>	<u>Mile stone</u>	<u>Responsibility</u>
10.	4	Jan. 79	VHW/Dai training starts	RTC/Contractor
11.	4	Jan. 79	Preassignment training for BHCs starts	RTC/Contractor
12.	4	Jan. 79	Continuing Ed/Supv. of BHCs starts	RTC/Contractor
13.	4	Jan. 79	BHC equipment and supplies ordered	MOPH/Contractor
14.	6	Mar. 79	Drug packaging equipment contract signed	MOPH/Contractor
15.	6	Mar. 79	Survey of Provincial Hospitals starts	Contractor
16.	9	June 79	Baseline data collected	Contractor
17.	9	June 79	Provincial Hospital Survey completed	Contractor
18.	9	June 79	BHC construction complete in Girishk	MOPH
19.	9	June 79	Preassignment training for already assigned BHC personnel completed	RTC/Contractor
20.	9	June 79	Recruit and begin training of non-physician managers	MOPH/RTC/Contractor
21.	9	June 79	BHC health education curriculum completed	MOPH/Contractor
22.	9	June	BHC continuing education curriculum completed	MOPH/Contractor
23.	13	Oct. 79	Baseline analysis complete	MOPH/Contractor
24	12	Oct. 79	VHW/Dai continuing education curriculum completed	MOPH/Contractor

<u>No.</u>	<u>Project Month</u>	<u>Calendar Month</u>	<u>Milestone</u>	<u>Responsibility</u>
25.	13	Oct. 79	Home Visiting Program test starts	RTC/BHC Contractor
26.	13	Oct. 79	Community Based Distribution test starts	RTC/BHC/Contractor
27.	13	Oct. 79	MCH and Oral Rehydration clinics established in 50% Girishk BHCs	MOPH
28.	13	Oct. 79	Drugs imported and distributed	MOPH
29.	13	Oct. 79	Girishk BHC equipment and supplies in place	MOPH
30.	13	Oct. 79	Non-physician managers trained and in place	RTC/Contractor
31.	13	Oct. 79	Sanitarian public health and supervision curriculum completed	MOPH/Contractor
32.	13	Oct. 79	Logistic systems manuals completed	Contractor
33.	13	Oct. 79	Information systems manuals completed	Contractor
34.	15	Dec. 79	50% VHW/Dais in Girishk trained and in place	RTC/Contractor
35.	15	Dec. 79	Drug packaging equipment in place	MOPH/Contractor
36.	15	Dec. 79	BHC preassignment curriculum completed	MOPH/Contractor
37.	15	Dec. 79	All BHCs in Girishk visited at least twice for continuing education	RTC/Contractor
38.	16	Jan. 80	Continuing education for VHW/Dais starts	RTC/Contractor

<u>No.</u>	<u>Project Month</u>	<u>Calendar Month</u>	<u>Milestone</u>	<u>Responsibility</u>
39.	18	Mar. 80	RTC training manual for trainers completed	Contractor
40.	18	Mar. 80	MCH and Oral Rehydration clinics established in all Girishk BHCs	MOPH
	21	June 80	Continuing education for 50% VHW/Dais completed	RTC/Contractor
42.	21	June 80	All BHCs in Girishk visited at least four times for continuing education	RTC/Contractor
43.	25	Oct. 80	BHC construction complete	MOPH
44.	27	Dec. 80	1981 Baseline survey initiated	Contractor/RTC
45.	27	Dec. 80	100% VHW/Dais trained and in place in Girishk	RTC/Contractor
46.	27	Dec. 80	MOPH Management Training Unit curriculum, materials and manual complete	Contractor/MOPH
47.	27	Dec. 80	Manpower analysis complete	Contractor/MOPH
48.	30	Mar. 81	Home Visiting evaluated	Health Planner
49.	30	Mar. 81	Community Distribution evaluated	Health Planner
50.	31	April 81	Baseline data analyzed	MOPH/Contractor/ Health Planner
51.	33	June 81	Continuing education for 100% VHW/Dais in Girishk and 50% second round complete	RTC/Contractor
52.	33	June 81	RTC providing continuing education and supervision in site visits to all BHCs at least four times a year	RTC
53.	34	July 81	Evaluation complete	Health Planner
54.	35	Sept. 81	Final Report	Contractor



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2. Management Team

USAID seeks a departure from ordinary competitive practice pursuant to Title 41, Federal Procurement Regulations, Chapter 7, Agency for International Development, Sub-part 7-3.1 - Use of Negotiation.

Specifically, USAID believes Management Sciences for Health Inc. should have their current Phase I contract amended to meet the Phase II task and maintain the current Management Team. Chapter 7 provides that negotiation without solicitation of proposals may be undertaken in the case of contract amendments which provide for the continuation of activities or assistance which in the judgment of the contracting officer are designed to meet a goal which is substantially similar to the goal stated in the original contract. That is the case in this instance. The Girishk Experiment and central Ministry management assistance arise out of Phase I, and while adding intensity of coverage, do not increase the scope of the MSH activity. Indeed, the scope is sharpened to focus on health delivery systems in a defined region.

A second category for negotiation is also applicable under Chapter 7: negotiation without solicitation may be undertaken for contracts for which one firm or institution has exclusive or predominate capability. Chapter 7 outlines the following factors which should be considered in preparing a "justification".

- What capability does MSH have which is important to the specific efforts and clearly makes it more desirable than another firm?

in Afghanistan health projects

Management Sciences for Health, under Phase I, conceptualized and initiated ~~the~~ Village Health Worker and Dai programs. They conceptualized and initiated the curricula and training programs for village-level workers and BHC workers. The Regional Training Center is a creation of MSH as is the Home Visiting Program and Community Based Distribution test. The Revolving Fund for drug purchases is their concept and design. What we know of management systems in the MOPH, in fact, is due entirely to MSH. All of these elements were conceptualized and developed during Phase I. Most are still in an experimental stage, and their nature and potential are the unique conceptual property of MSH. ~~Another firm would undoubtedly have to rethink the entire basic health service model, in effect repeating Phase I. There is no question but that at the end of Phase II, solicitation of proposals will be appropriate. At that point systems would have been defined and tested, and implementation support could be undertaken as a separate activity.~~

A

- What prior experience of a highly specialized nature does MSH possess which is vital to the proposed effort?

~~MSH is the sole contractor exploring new concepts of health delivery with the MOPH in Afghanistan. Phase I experiments are still in process and will be the substantive take-off for the Phase II test.~~

B ~~In the particular instance of the recent revolution, MSH represents the only U.S. advisors working in the MOPH. With the prospect of new advisors from other countries now entering the Ministry, it is even more important that the firm responsible for conceptualizing the proposed national basic health services system be available to maintain their critical role - a role which could guide other donors or which could pass to others with a gap in time and discontinuity in personnel~~

If time schedules are critical, why are they critical and why can MSH best meet them?

C MSH is already mobilized in Afghanistan. They have five people here that can begin work on the Phase II workplan immediately. That is a distinct and unique advantage.

Time is critical for two reasons. As noted above, discontinuity of U.S. input at the MOPH could displace the pivotal role AID has come to play in the Ministry. In that sense, it is continuity not time that is critical. In terms of timing, the new Government has made a commitment to the people of Afghanistan that they will take immediate steps to improve rural health. We are poised and ready to assist in that effort. Other donors are similarly poised. Initiation of a new contract team would delay implementation for at least six months. The Government has made it clear that they are not prepared to tolerate that kind of time lapse. If the AID leadership role is lost, a new donor could propose a new health model and, in essence, start a new project.

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The Management Team will be self-supporting in terms of administrative support. USAID management facilities will not be available for contractor support. As pointed out above, three members of the Management Team will be resident in the Girishk Region. Specific allowance for housing renovation will be include in the contract.

Given the integrated nature of the Girishk experiment, it is proposed that no new members of the MSH Team be authorized to proceed to Afghanistan until all members are recruited and prepared to travel. If the new members are not recruited and available to travel 90 days after contract signature, AID will reserve the right to terminate the contract and will then pursue contracting through usual competitive procedures.

3. Evaluation Team

Funds for independent evaluation are provided in the Phase II project. If Management Sciences for Health is contracted for the Management Team, it will be necessary to have the Evaluation Team selected and in Afghanistan not later than October 1978. To meet this schedule, it is probably most desirable to utilize a Health Planner already under contract to the Agency. Given the importance of the project, its significance for the national health care in Afghanistan and its possible relevance to other basic health projects around the world, the Health Planner should have substantial experience in international health and be prepared to make a major commitment of time to the project. Project funding is provided for both U.S. and local Afghan evaluation design and analysis support.

If it is necessary to solicit proposals for the Evaluation Team, it is recommended that AID short-list selected candidates immediately to facilitate selection, contracting and mobilization.

4. Physical Facilities

The Mission considered the assignment of a Construction Management Advisor to the MOPH for the construction component of the Phase II project. Given the advanced state of project implementation, noted improvements in construction management within the MOPH over the past six months and the limited role of facilities construction in MOPH plans, it has been decided not to include the Advisor in the Phase II project.

The Mission will continue to use Fixed Amount Reimbursement for the BHC construction component. Before signing FAR Agreements for the 38 buildings not yet covered by such Agreements, the MOPH will have to submit to USAID a plan for the design, construction, supervision and

Table F.1

ESTIMATED AID COSTS FOR ALL 50 BASIC HEALTH CENTERS

First 12 BHCs

Agreed Cost 12 BHCs	Afs. 41,709,902*
AID Cost (x0.75)	31,282,426
AID Cost in Dollars (÷ 42)	\$ 744,820
Allowance of 10% for currency fluctuations	74,482
Total Estimated Cost	\$ 819,302
Amount Obligated in Project Agreement	<u>537,911</u>
Additional Fund Required	\$ 281,390

Remaining 38 BHCs

Type I BHCs 3 @ Afs. 8,563,943	Afs. 25,991,829
Type II BHCs 5 @ Afs. 4,291,352	Afs. 21,456,760
Type III BHCs 30 @ Afs. 2,980,683	Afs. <u>89,420,490</u>
Total Estimate Cost (1977 Price)	Afs. 136,869,079
AID Cost (x0.75)	Afs. 102,651,809
AID Cost in Dollars (÷ 42)	\$ 2,444,091
Allow 20% for Inflation & Currency Fluctuations	<u>438,818</u>
Estimated Total AID Cost	\$ 2,932,909

* Agreed Cost: between USAID and MOPH October 1977

△ Allowance because FAR Agreement not yet signed by MOPH

Table E.2

ESTIMATED COSTS FOR BHCs
(1977 Price)

CLASS I BHC

Basic Health Center Building	2,108,394
Doctor's Quarters	728,598
Officer's Quarters	728,598
Administration and Classrooms	1,371,839
Kitchen and Dining Room	526,870
Bachelor's Quarters	704,328
Utilities (Water Tower, Septic Tank, Water Distribution)	284,568
Compound Wall and Gate	869,472
Dormitory	<u>1,371,267</u>
Afs.	8,663,943

CLASS II BHC

Basic Health Center Building	2,078,303
Doctor's Quarters	717,327
Bachelor's Quarters	693,432
Utilities (Water Tower, Septic Tank, Water Distribution)	212,290
Compound Wall and Gate	<u>590,000</u>
Afs.	4,291,352

CLASS III BHC

Basic Health Center Building	767,634
Doctor's Quarters	717,327
Bachelor's Quarters	693,432
Utilities (Water Tower, Septic Tank, Water Distribution)	212,290
Compound Wall and Gate	<u>590,000</u>
Afs.	2,980,683

- vehicles Code 000
- equipment for warehouses, BHCs and RTCs Code 941 and Cooperating Country

USAID is considering submission of a source/origin waiver request for pharmaceuticals. U.S. procurement would be disfunctional in the sense that it would redirect procurement from current channels and would impede routinization of procurement practice. It would also add cost, and the current estimate of \$750,000 would increase by 50 percent. The Mission will advise following resumption of discussions with Government.

6. Local Support Costs

To insure that funds are used prudently and for project purpose achievement in Girishk, a disbursement system with the following components is planned:

- training support financing will be accomplished by an initial advance payment followed by four semi-annual fixed installments and a final payment.
- prior to making the initial advance, a workplan for the Girishk Experiment including detailed task assignments, schedules, output targets and performance measures will be submitted for USAID approval.
- prior to semi-annual installments, a statement of procedures for semi-annual review, such procedure to include the subjects to be regularly covered at each review meeting.
- prior to semi-annual installments, evidence that staff has been assigned in Girishk in terms with the output indicators contained in the Logical Framework.
- agreement by the Government at the time of the first semi-annual installment to meet 10 percent of future annual training support costs; and agreement at the time of the third semi-annual installment to meet 20 percent of future annual training support costs;
- evidence that the Phase II project is being implemented in accordance with approved workplans; and
- evidence that the performance targets required to justify a particular installment, as set forth in Implementation Letters based on agreed workplans, have been met with regard to training capacity, trained manpower, management development and operation, establishment of physical facilities, staffing and other items to be enumerated.

7. Conditions Precedent and Covenants

The following are illustrative of the Conditions Precedent and Covenants that the USAID Mission proposes to negotiate with the Government of Afghanistan. Although the Government appears in accord with the purposes of the illustrative list, officials have consistently expressed concern with the number of conditions and the specificity indicated. The final text of the Conditions Precedent and Covenants will, therefore, evolve from Project Agreement negotiations.

1. Conditions Precedent to Disbursement for Technical Assistance

Prior to the first disbursement of AID funds for technical assistance, the Government of Afghanistan will furnish:

- a preliminary plan for Basic Health Services outlining strategy and objectives, organization, costs and financing;
- evidence that a contract amendment for technical assistance has been entered into for the services outlined in this Project Paper; and
- evidence that funds other than those provided by AID which are necessary for the timely performance of the contract have been made available.

2. Conditions Precedent to Disbursement of Funds for Participants

- a training plan relating proposed training to project purposes as outlined herein.

3. Conditions Precedent to Disbursement of Funds for Commodities

- for contract support, evidence that a contract amendment for technical assistance has been entered into;
- for drugs, drug packaging equipment and vehicles prior approval of the IFP and approval of all awards; and
- for RTC/BHC/warehouse equipment, prior approval of the commodity lists and procurement procedures.

4. Conditions Precedent to Initial Disbursement for Local Support Costs

- a workplan for the Girishk Experiment and related training including detailed task assignments, schedules, output targets and performance measures for village workers, MOPH personnel and the Management Team.

5. Conditions Precedent to Additional Disbursements for Local Support Costs

- a statement of procedures for semi-annual review of Phase II progress;
- evidence that village-level workers and MOPH personnel have been recruited, trained and assigned in accord with the output indicators contained in the workplan submitted as a Condition Precedent to Initial Disbursement;
- agreement by the Government to meet 10 percent of the second and future semi-annual assessments of training support costs and 20 percent of the fourth and future semi-annual assessments of training support costs; and
- evidence that the performance targets required to justify a particular installment, as set forth in Implementation Letters based on agreed workplans, have been met.

6. Conditions Precedent to Final Disbursement for Local Support Costs

- submission of the project Evaluation and Management Team Final Report; and
- evidence that the Phase II project was implemented in accordance with approved workplans.

7. Conditions Precedent to Disbursement for Physical Facility Construction

- submission of a plan for the design, construction, supervision and monitoring including details of personnel assignment and evidence of budget to support the proposed construction program; and

- a signed FAR Agreement per instructions to be included in the first Implementation Letter.

8. Special Covenants

- the Government will carry out the Phase II project with sufficient manpower and funding to meet agreed performance targets for the project.
- the MOPH will undertake training programs in a timely and effective manner.
- as a part of meeting the project purpose, the MOPH will seek to have an integrated basic health care system operating in Girishk within two years.
- as a part of meeting project purpose, the MOPH will assure that an effective management support infrastructure is developed and made operational in a timely manner.
- the MOPH will engage long-term technical advisors in accord with the design outlined in this Project Paper.

PROJECT AUTHORIZATION AND REQUEST FOR ALLOTMENT OF FUNDS

Name of Country/Entity: Afghanistan Name of Project: Basic Health Services
Number of Project: 306-0144

Pursuant to Part I. Chapter 1. Section 104 of the Foreign Assistance act of 1961, as amended, I hereby authorize a Grant to Afghanistan, the "Cooperating Country", of not to exceed 3 million United States Dollars (\$2,800,000), the "Authorized Amount", to help in financing certain foreign exchange and local currency costs of goods and services required for the project as described in the following paragraph.

The project consists of assistance to initiate and sustain a basic health care system in the Girishk Region of Afghanistan to test the system's technical feasibility and economic viability. It will also develop management systems at the central Ministry level capable of supporting the regional health care system and then subsequently a national system (hereinafter referred to as the "Project").

I approve the total level of A.I.D. appropriated funding planned for this project of not to exceed 14 million United States Dollars (\$13,984,000), of which \$13,984,000 will be Grant funded, including the funding authorized above, during the period FY 1978 through FY 80. I approve further increments during that period of Grant funding up to \$11,184,000, subject to the availability of funds in accordance with A.I.D. allotment procedures.

I hereby authorize the initiation of negotiation and execution of the

Project Agreement by the officer to whom such authority has been delegated in accordance with A.I.D. regulations and Delegations of Authority subject to the following essential terms and covenants and major conditions; together with such other terms and conditions as A.I.D. may deem appropriate:

a. Source and Origin of Goods and Services

Except for Ocean Shipping, goods and services financed by A.I.D. under the project shall have their source and origin in the Cooperating Country or in countries included in A.I.D. Geographic Code 941, except as A.I.D. may otherwise agree in writing.

b. Conditions Precedent to Disbursement for Technical Assistance

Prior to the first disbursement of A.I.D. funds for technical assistance, the Government of Afghanistan will furnish:

- a preliminary plan for Basic Health Services outlining strategy and objectives, organization, costs and financing;
- evidence that a contract amendment for technical assistance has been entered into for the services outlined in this Project Paper; and
- evidence that funds other than those provided by A.I.D. which are necessary for the timely performance of the contract have been made available.

c. Conditions Precedent to Disbursement of Funds for Participants

- a training plan relating proposed training to project purposes as outlined herein.

d. Conditions Precedent to Disbursement of Funds for Commodities

- for contract support, evidence that a contract amendment for technical assistance has been entered into;
 - for drugs, drug packaging equipment and vehicles, prior approval of the IFP and approval of all awards; and
 - for RTC/BHC/warehouse equipment, prior approval of the commodity lists and procurement procedures.
- e. Conditions Precedent to Initial Disbursement for Local Support Costs
- a workplan for the Girishk Experiment and related training including detailed task assignments, schedules, output targets and performance measures for village workers, MOPH personnel and the Management Team.
- f. Conditions Precedent to Additional Disbursements for Local Support Costs
- a statement of procedures for semi-annual review of Phase II progress;
 - evidence that village-level workers and MOPH personnel have been recruited, trained and assigned in accord with the output indicators contained in the workplan submitted as a Condition Precedent to Initial Disbursement;
 - agreement by the Government to meet 10 percent of the second and future semi-annual assessments of training support costs and 20 percent of the fourth and future semi-annual assessments of training support costs; and

- evidence that the performance targets required to justify a particular installment, as set forth in Implementation Letters based on agreed workplans, have been met.

g. Conditions Precedent to Final Disbursement for Local Support Costs

- submission of the project Evaluation and Management Team Final Report; and
- evidence that the Phase II project was implemented in accordance with approved workplans.

h. Conditions Precedent to Disbursement for Physical Facility Construction

- submission of a plan for the design, construction, supervision and monitoring including details of personnel assignment and evidence of budget to support the proposed construction program; and
- a signed FAR Agreement per instructions to be included in the first Implementation Letter.

i. Special Covenants

- the Government will carry out the Phase II project with sufficient manpower and funding to meet agreed performance targets for the project.
- the NUPH will undertake training programs in a timely and effective manner.

as a part of meeting the project purpose, the MOPH will seek to have an integrated basic health care system operating in Girishk within two years.

- as a part of meeting project purpose, the MOPH will assure that an effective management support infrastructure is developed and made operational in a timely manner.
- the MOPH will engage long-term technical advisors in accord with the design outlined in this Project Paper.

j. Approval to Negotiate the Technical Assistance Contract

- authorization is given to amend the A.I.D. contract with Management Sciences for Health Inc. for the technical assistance described in the Project Paper.

k. Waiver of GOA Contribution Requirement

- the twenty-five percent contribution requirement from the GOA is waived.

l. Inclusion of Phase I Construction

- Phase I construction is incorporated into the Phase II project.

Clearances:

Signature: _____

Office

Date

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UNITED STATES OF AMERICA
AGENCY FOR INTERNATIONAL DEVELOPMENT

KABUL, AFGHANISTAN

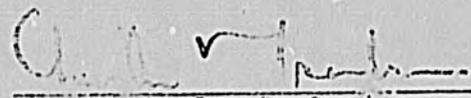
هيئة انكشاف بين العالمين اذ ابراع منظمة امريكا
كابل افغانستان

OFFICE OF THE DIRECTOR

دفتر رئيس

CERTIFICATION PURSUANT TO SECTION 611 (c)
OF THE FOREIGN ASSISTANCE ACT OF 1961
AS AMENDED

I, Charles R. Grader, the principal officer of the Agency for International Development in Afghanistan, having taken into account, among other things, the maintenance and utilization of Basic Health Centers (BHC) in the country, AID experience with the Phase I BHS Project, the continuing assistance of UNICEF to BHC equipment requirements, progress in staffing the MOPH Construction Unit, the proposed management assistance and the supervisory support and construction incentive component included in the Phase II project, due hereby certify that in my judgment, Afghanistan has both the financial capability and the human resources capability to effectively maintain and utilize the capital assistance project, Basic Health Services Phase II.



Charles R. Grader

JUN 3 1978

Date

COUNTRY CHECKLIST.

Below are, first, statutory criteria applicable generally to FAA funds, and then, criteria applicable to individual fund sources: Development Assistance and Security Supporting A...

JUDICIAL CRITERIA FOR COUNTRY

- Part III, D. Project Paper
- State 125909
- No
- No
- State 125909
- No
- No
- No
1. FAA Sec. 110. Can it be demonstrated that contemplated assistance will directly benefit the needy? If not, has the department or State determined that this government has engaged in consistent pattern of gross violations of internationally recognized human rights?
2. FAA Sec. 101. Has it been determined that the government of recipient country has failed to take adequate steps to prevent narcotics drugs and other controlled substances (as defined by the Comprehensive Drug Abuse Prevention and Control Act of 1970) produced or processed, in whole or in part, in such country, or transported through such country, from being sold illegally within the jurisdiction of such country to U.S. Government personnel or their dependents, or from entering the U.S. unlawfully?
3. FAA Sec. 600(a). Does recipient country furnish assistance to Cuba or fail to take appropriate steps to prevent ships or aircraft under its flag from carrying cargo to or from Cuba?
4. FAA Sec. 600(b). If assistance is to a government, has the Secretary of State determined that it is not controlled by the International Communist movement?
5. FAA Sec. 600(c). If assistance is to government, is the government liable as debtor or unconditional guarantor on any debt of a U.S. citizen for goods or services furnished or ordered where (a) such citizen has exhausted available legal remedies and (b) debt is not denied or satisfied by such government?
6. FAA Sec. 600(d) (1). If assistance is to a government, has it (including government agencies or subdivisions) taken any action which has the effect of nationalizing, expropriating, or otherwise seizing ownership or control of property of U.S. citizens or entities beneficially owned by them without taking steps to discharge its obligations toward such citizens or entities?

COUNTRY CHECKLIST

17. IAA Sec. 620(f); App. Sec. 108. Is recipient country a Communist country? Will assistance be provided to the Democratic Republic of Vietnam (North Vietnam), South Vietnam, Cambodia or Laos? State 125909
18. IAA Sec. 620(i). Is recipient country in any way involved in (a) subversion of, or military aggression against, the United States or any country receiving U.S. assistance, or (b) the planning of such subversion or aggression? No
19. IAA Sec. 620(j). Has the country permitted, or failed to take adequate measures to prevent, the damage or destruction, by mob action, of U.S. property? No
20. IAA Sec. 620(l). If the country has failed to institute the investment guaranty program for the specific risks of expropriation, inconvertibility or nationalization, has the AID Administrator within the past year considered denying assistance to such government for this reason? No
21. IAA Sec. 620(o); Fishermen's Protective Act, Sec. 5. If country has seized, or imposed any penalty or sanction against, any U.S. fishing activities in international waters,
- a. has any deduction required by Fishermen's Protective Act been made?
- b. has complete denial of assistance been considered by AID Administrator?
22. IAA Sec. 620(q); App. Sec. 504. (a) Is the government of the recipient country in default on interest or principal of any AID loan to the country? (b) Is country in default exceeding one year on interest or principal on U.S. loan under program for which App. Act appropriates funds, unless debt was earlier disputed, or appropriate steps taken to cure default? No
23. IAA Sec. 620(s). "If contemplated assistance is development loan (including Alliance loan) or security supporting assistance, has the Administrator taken into account the percentage of the country's budget which is for military expenditures, the amount of foreign exchange spent on military equipment and the amount spent for the purchase of sophisticated weapons systems?" (An affirmative answer may refer to the record of the taking into account, e.g.: "Yes as reported in annual report on implementation of Sec. 620(s)." This report is prepared at the time of approval by the Administrator of the Operational Year Budget.": Not Applicable

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Upward changes in the Sec. 620(s) factors occurring in the course of the year; of sufficient significance to indicate that an affirmative answer might need review (and still be reported, but the statutory checklist will not normally be the preferred vehicle to do so.)

14. IAA Sec. 620(t). Has the country severed diplomatic relations with the United States? If so, have they been resumed and have new bilateral assistance agreements been negotiated and entered into since such resumption?

No

15. IAA Sec. 620(u). What is the payment status of the country's U.S. obligations? If the country is in arrears, were such arrears taken into account by the AID Administrator in determining the current AID Operational Year Budget?

Not in Arrears

16. IAA Sec. 620A. Has the country granted immunity from prosecution to any individual or group which has committed an act of international terrorism?

No

17. IAA Sec. 606. Does the country object, on basis of race, religion, national origin or sex, to the presence of any visitor or employee of the U.S. there to carry out economic development program under IAA?

No

18. IAA Sec. 609. Has the country delivered or received nuclear reprocessing or enrichment equipment, materials or technology, without specified arrangements or safeguards, etc.?

No

19. IAA Sec. 901. Has the country denied its citizens the right or opportunity to emigrate?

It is permitting some citizens to emigrate.

EMIGRATION CRITERIA FOR COUNTRY

1. Development Assistance Country Criteria

a. IAA Sec. 102(c), (d). Have criteria been established, and taken into account, to assess commitment and progress of country in effectively involving the poor in development, on such indexes as: (1) small-farm labor intensive agriculture, (2) reduced infant mortality, (3) population growth, (4) equality of income distribution, and (5) unemployment.

CDSS, April, 1978.

b. IAA Sec. 201(b)(5), (7) & (8); Sec. 208; 211(a)(4), (7). Describe extent to which country is:

CDSS, April, 1978/ABS June, 1978

(1) Making appropriate efforts to increase food production and improve means for food storage and distribution.

COUNTRY CHECKLIST

- (c) Creating a favorable climate for foreign and domestic private enterprise and investment.
- (d) Increasing the public's role in the developmental process.
- (i) (a) Allocating available budgetary resources to development.

(b) Diverting such resources for unnecessary military expenditure and intervention in affairs of other free and independent nations.
- (h) Halting economic, social, and political reforms such as tax collection improvements and changes in land tenure arrangements, and making progress toward respect for the rule of law, freedom of expression and of the press, and recognizing the importance of individual freedom, initiative, and private enterprise.
- (a) Otherwise responding to the vital economic, political, and social concerns of its people, and demonstrating a clear determination to take effective self-help measures.

c. FAA Sec. 201(b), 211(a). Is the country among the 20 countries in which development assistance loans may be made in this fiscal year, or among the 40 in which development assistance grants (other than for self-help projects) may be made?

Yes

d. FAA Sec. 115. Will country be furnished, in same fiscal year, either security supporting assistance, or Middle East peace funds? If so, is assistance for population programs, humanitarian aid through international organizations, or regional programs?

No

2. Security Supporting Assistance Country Criteria

Not Applicable

a. FAA Sec. 502B. Has the country engaged in a consistent pattern of gross violations of internationally recognized human rights? Is program in accordance with policy of this Section?

b. FAA Sec. 531. Is the Assistance to be furnished to a friendly country, organization, or body eligible to receive assistance?

c. FAA Sec. 609. If commodities are to be granted so that sale proceeds will accrue to the recipient country, have Special Account (counterpart) arrangements been made?

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STANDARD ITEM CHECKLISTA. Procurement

1. FAA Sec. 602. Are there arrangements to permit U.S. small business to participate equitably in the furnishing of goods and services financed? Yes. Project Paper Part IV, B.5.
2. FAA Sec. 604(a). Will all commodity procurement financed be from the U.S. except as otherwise determined by the President or under delegation from him? Procurement is in accord with AID Handbooks. Project Paper Part IV, B.5.
3. FAA Sec. 604(d). If the cooperating country discriminates against U.S. marine insurance companies, will agreement require that marine insurance be placed in the U.S. on commodities financed? Not Applicable
4. FAA Sec. 604(e). If offshore procurement of agricultural commodity or product is to be financed, is there provision against such procurement when the domestic price of such commodity is less than parity? Not Applicable
5. FAA Sec. 608(a). Will U.S. Government excess personal property be utilized wherever practicable in lieu of the procurement of new items? Yes - particularly in housing support of the Management Team.
6. MEA Sec. 401(b). (a) Compliance with requirement that at least 50 per centum of the gross tonnage of commodities (computed separately for dry bulk carriers, dry cargo liners, and tankers) financed shall be transported on privately owned U.S. flag commercial vessels to the extent that such vessels are available at fair and reasonable rates. Will be included in Grant Agreement and Implementation Letters
7. FAA Sec. 621. If technical assistance is financed, will such assistance be furnished to the fullest extent practicable as goods and professional and other services from private enterprise on a contract basis? If the facilities of other Federal agencies will be utilized, are they particularly suitable, not competitive with private enterprise, and made available without undue interference with domestic programs? Yes - See Part IV, B.2.

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8. International Air Transport. Fair Competitive Practices Act, 1974

Yes. Will be provided in contracts.

If air transportation of persons or property is financed on grant basis, will provision be made that U.S.-flag carriers will be utilized to the extent such service is available?

B. Construction

1. FAA Sec. 601(d). If a capital (e.g., construction) project, are engineering and professional services of U.S. firms and their affiliates to be used to the maximum extent consistent with the national interest?

See Project Paper Part IV, B.4. Technical assistance not required.

2. FAA Sec. 611(c). If contracts for construction are to be financed, will they be let on a competitive basis to maximum extent practicable?

See Project Paper Part IV, B.4.

3. FAA Sec. 620(k). If for construction of productive enterprise, will aggregate value of assistance to be furnished by the U.S. not exceed \$100 million?

Not Applicable

C. Other Restrictions

1. FAA Sec. 201(d). If development loan, is interest rate at least 2% per annum during grace period and at least 3% per annum thereafter?

Not Applicable

2. FAA Sec. 301(d). If fund is established solely by U.S. contributions and administered by an international organization, does Comptroller General have audit rights?

Not Applicable

3. FAA Sec. 620(h). Do arrangements preclude promoting or assisting the foreign aid projects or activities of Communist-Bloc countries, contrary to the best interests of the U.S.?

There is no association with AID projects or activities of Communist-Bloc countries contemplated.

4. FAA Sec. 635(i). Is financing not permitted to be used, without waiver, for purchase, long-term lease, or exchange of motor vehicle manufactured outside the U.S. or guaranty of such transaction?

Vehicle procurement is limited to the U.S.

5. Will arrangements preclude use of financing:

- | | |
|---|-----------------------|
| <p>a. <u>FAA Sec. 114.</u> To pay for performance of abortions or to motivate or coerce persons to practice abortions, to pay for performance of involuntary sterilization, or to coerce or provide financial incentive to any person to practice sterilizations?</p> | <p>Yes</p> |
| <p>b. <u>FAA Sec. 620(q).</u> to compensate owners for expropriated nationalized property?</p> | <p>Not Applicable</p> |
| <p>c. <u>FAA Sec. 660.</u> to finance police training or other law enforcement assistance, except for narcotics programs?</p> | <p>" "</p> |
| <p>d. <u>FAA Sec. 662.</u> for CIA activities?</p> | <p>" "</p> |
| <p>e. <u>App. Sec. 103.</u> to pay pensions, etc., for military personnel?</p> | <p>" "</p> |
| <p>f. <u>App. Sec. 105.</u> to pay U.N. assessments?</p> | <p>" "</p> |
| <p>g. <u>App. Sec. 106.</u> to carry out provisions of FAA Sections 200(d) and 251(h)? (transfer to multilateral organization for lending).</p> | <p>" "</p> |
| <p>h. <u>App. Sec. 112.</u> To finance the export of nuclear equipment, fuel, or technology or to train foreign nationals in nuclear fields?</p> | <p>" "</p> |
| <p>i. <u>App. Sec. 501.</u> to be used for publicity or propaganda purposes within U.S. not authorized by Congress?</p> | <p>" "</p> |

PROJECT CHECKLISTA. GENERAL CRITERIA FOR PROJECT1. App. Unnumbered; FAA Sec. 653(h)

(a) Describe how Committees on Appropriations of Senate and House have been or will be notified concerning the project:

(a) The Committees will be notified prior to authorization.

(b) Is assistance within (Operational Year Budget) country or international organization allocation reported to Congress (or not more than \$1 million over that figure plus 10%)?

(b) No.

2. FAA Sec. 611(a)(1). Prior to obligation in excess of \$100,000, will there be (a) engineering, financial, and other plans necessary to carry out the assistance and (b) a reasonably firm estimate of the cost to the U.S. of the assistance?

(a) Yes

(b) Part IV, B.4. of the Project Paper

3. FAA Sec. 611(a)(2). If further legislative action is required within recipient country, what is basis for reasonable expectation that such action will be completed in time to permit orderly accomplishment of purpose of the assistance?

Not Applicable

4. FAA Sec. 611(b); App. Sec. 101. If for water or water-related land resource construction, has project met the standards and criteria as per the Principles and Standards for Planning Water and Related Land Resources dated October 25, 1973?

Not Applicable

5. FAA Sec. 611(e). If project is capital assistance (e.g., construction), and all U.S. assistance for it will exceed \$1 million, has Mission Director certified the country's capability effectively to maintain and utilize the project?

Director's Certification included as Part IV, B.4 of Project Paper

6. FAA Sec. 209, 619. Is project susceptible of execution as part of regional or multilateral project? If so why is project not so executed? Information and conclusion whether assistance will encourage regional development programs. If assistance is for newly independent country, is it furnished through multilateral organizations or plans to the maximum extent appropriate?
7. FAA Sec. 601(a); (and Sec. 201(f) for development loans). Information and conclusions whether project will encourage efforts of the country to: (a) increase the flow of international trade; (b) foster private initiative and competition; (c) encourage development and use of cooperatives, credit unions, and savings and loan associations; (d) discourage monopolistic practices; (e) improve technical efficiency of industry, agriculture and commerce; and (f) strengthen free labor unions.
8. FAA Sec. 601(b). Information and conclusion on how project will encourage U.S. private trade and investment abroad and encourage private U.S. participation in foreign assistance programs (including use of private trade channels and the services of U.S. private enterprise).
9. FAA Sec. 612(b); Sec. 636(h). Describe steps taken to assure that, to the maximum extent possible, the country is contributing local currencies to meet the cost of contractual and other services, and foreign currencies owned by the U.S. are utilized to meet the cost of contractual and other services.
10. FAA Sec. 612(d). Does the U.S. own excess foreign currency and, if so, what arrangements have been made for its release?

The assistance is not directed at a regional problem, and the project will not encourage any regional programs. Afghanistan is not a newly independent country.

The basic health system, at the village level, is a private system. The testing of that system is the major purpose of the project. Other references are not applicable.

The GOA will contract with an American organization for management services. Drug commodities and equipment will also be supplied from the U.S.

Because the project is in the nature of a test, AID will finance the bulk of local costs. A gradual increase in GOA contribution is contemplated and a follow-on Sector Grant will be conditioned on GOA local support.

Afghanistan is not an excess currency country.

17 ISA 14. Are any FAA funds for FY 78 being used in this Project to construct, operate, maintain, or supply fuel for, any nuclear powerplant under an agreement for cooperation between the U.S. and any other country?

No such activity is financed under this assistance.

B. FUNDING CRITERIA FOR PROJECT

1. Development Assistance Project Criteria

a. FAA Sec. 102(c); Sec. 111; 281a.
Extent to which activity will (a) effectively involve the poor in development, by extending access to economy at local level, increasing labor-intensive production, spreading investment out from cities to small towns and rural areas; and (b) help develop cooperatives, especially by technical assistance, to assist rural and urban poor to help themselves toward better life, and otherwise encourage democratic private and local governmental institutions?

The project is premised on a village health worker and traditional mid-wife - village recruited personnel. The project will also focus-on health education and local preventive practices. See Project Paper Part III, D.

b. FAA Sec. 103, 103A, 105, 106, 107.
Is assistance being made available: (include only applicable paragraph -- e.g., a, b, etc. -- which corresponds to source of funds used. If more than one fund source is used for project, include relevant paragraph for each fund source.)

- (1) (103) for agriculture, rural development or nutrition; if so, extent to which activity is specifically designed to increase productivity and income of rural poor; (103A) if for agricultural research, 's full account taken of needs of small farmers;
- (2) (104) for population planning or health; if so, extent to which activity extends low-cost, integrated delivery systems to provide health and family planning services, especially to rural areas and poor;

See Part III of Project Paper.

- (3) (105) for education, public administration, or human resources development; if so, extent to which activity strengthens nonformal education, makes formal education more relevant, especially for rural families and urban poor, or strengthens management capability of institutions enabling the poor to participate in development;
- (4) (106) for technical assistance, energy, research, reconstruction, and selected development problems; if so, extent activity is:
- (a) technical cooperation and development, especially with U.S. private and voluntary, or regional and international development, organizations;
 - (b) to help alleviate energy problem;
 - (c) research into, and evaluation of, economic development processes and techniques;
 - (d) reconstruction after natural or manmade disaster;
 - (e) for special development problem, and to enable proper utilization of earlier U.S. infrastructure, etc., assistance;
 - (f) for programs of urban development, especially small labor-intensive enterprises, marketing systems, and financial or other institutions to help urban poor participate in economic and social development.
- (5) (107) by grants for coordinated private effort to develop and disseminate intermediate technologies appropriate for developing countries.

- c. FAA Sec. 110(a); Sec. 208(a). Is the recipient country willing to contribute funds to the project,

The GOA is a "relatively least developed country" which a waiver of the twenty-five percent requirement is appropriate

and in what manner has or will it provide assurances that it will provide at least 25% of the costs of the program, project, or activity with respect to which the assistance is to be furnished (or has the latter cost-sharing requirement been waived for a "relatively least-developed" country)?

d. FAA Sec. 110(b). Will grant capital assistance be disbursed for project over more than 3 years? If so, has justification satisfactory to Congress been made, and efforts for other financing, or is the recipient country "relatively least developed?"

No.

e. FAA Sec. 207; Sec. 113. Extent to which assistance reflects appropriate emphasis on; (1) encouraging development of democratic, economic, political, and social institutions; (2) self-help in meeting the country's food needs; (3) improving availability of trained workerpower in the country; (4) programs designed to meet the country's health needs; (5) other important areas of economic, political, and social development, including industry; free labor unions, cooperatives, and Voluntary Agencies; transportation and communication; planning and public administration; urban development, and modernization of existing laws; or (6) integrating women into the recipient country's national economy.

For (3)/(4) and (6) see Part III of the Project Paper

f. FAA Sec. 281(b). Describe extent to which program recognizes the particular needs, desires, and capacities of the people of the country; utilizes the country's intellectual resources to encourage institutional development; and supports civic education and training in skills required for effective participation in governmental and political processes essential to self-government.

See Part III, A and D of the Project Paper.

g. FAA Sec. 201(b)(2)-(4) and -(8); Sec. 201 (c); Sec. 211(a)(1)-(3) and -(8).
Does the activity give reasonable promise of contributing to the development of economic resources, or to the increase of productive capacities and self-sustaining economic growth; or of educational or other institutions directed toward social progress? Is it related to and consistent with other development activities, and will it contribute to realizable long-range objectives? And does project paper provide information and conclusion on an activity's economic and technical soundness?

See Part III B and C of the Project Paper

h. FAA Sec. 201(b)(6); Sec. 211 (a)(5),(6).
Information and conclusion on possible effects of the assistance on U.S. economy, with special reference to areas of substantial labor surplus, and extent to which U.S. commodities and assistance are furnished in a manner consistent with improving or safeguarding the U.S. balance-of-payments position.

Technical assistance and major equipment items will be procured from the U.S. No adverse affect on the U.S. balance of payments is anticipated.

TRADITIONAL HEALTH CARE
IN THE NEAR EAST

by

BARBARA L.K. FILLSBURY

A Report Prepared
for the
U.S. Agency for International Development
Washington D.C.

March 1976

Contract No. AID/NE-C-1395

A F G H A N I S T A N

A. HEALTH AND POPULATION OVERVIEW

Afghanistan stands out among the seven countries studied in two regards. First, its population suffers perhaps the poorest level of health, challenged only by Yemen in this unfortunate regard. Second, the Government of Afghanistan appears to be one of if not the most interested of the seven countries' governments in a primary health care strategy for bringing improved services to the rural poor.

A.1. Population Composition and Distribution

Afghanistan has never had an official population census. Various Government Ministries cite estimates between 14.5 and 17 million although the actual number may be closer to 12 million.¹ Approximately 1 to 2 million are nomadic or semi-nomadic pastoralists. Of the sedentary population about 85 percent is rural and 15 percent urban. The sedentary population lives where there is water. Its greatest concentration is in irrigation project areas. There is great ethnic heterogeneity and in-group identification. Nearly each group speaks its own language—Pushtu, Dari, Uzbek, Turkoman, Kirghiz, Baluchi, and so on.

A.2. Population and Health Status

a) Population. Afghanistan's population is young and characterized by high fertility and high mortality. Vital rates are only rough approximations. The crude birth rate is estimated at 50 per 1000 persons, the crude death rate about 25 per 1000. Infant mortality is believed to be about 180 per 1000 live births and maternal mortality 640 per 100,000. The population growth rate is probably about 2.5 percent per annum. Life expectancy at birth is estimated as only 41 years. Among persons age 15 and above, only some 14 percent are literate.²

b) Health. There is neither vital registration nor an effective system of disease reporting. Causes of death are often reconstructed from relatives' unschooled memories. Many children

¹ Afghan Demographic Studies 1975.

² For more descriptive information see Dupree (1970) and Afghan Demographic Studies (1975).

die of diseases which in themselves are easily preventable (e.g. measles, tetanus, and diarrheal dehydration). In a majority of cases it is the combination of disease and malnutrition that kills. Main causes of adult debility and death are reported to be malaria, tuberculosis, trachoma, venereal disease, gastrointestinal infection, and nutritional deficiency diseases.

A.3. Health and Population Planning

The Ministry of Public Health has begun trying during the past decade to develop a health center network reaching into rural areas. The Government has sought assistance from foreign donors, including AID, and shows willingness to make policy changes to facilitate health programming.¹ The groundwork has been done for a health care system of hospitals in the cities and provincial capitals and Basic Health Centers in the most peripheral minor civil divisions (wote-swalis). At least 106 "BHCs" are now functioning. This strategy, however, reaches only some 20 percent of the population. The great majority of Afghanistan's 18,000 villages lie far from a BEC.²

Experiments are now underway that may have promise for extending services to an additional 60 percent of the population. One is training the traditional birth attendants (indigenous midwives) and upgrading their skills for home delivery and recognition of high-risk pregnancies. The midwives receive financial support from the Government.

Another is recruitment and local training of men and women as Village Health Workers. The "VHWs" are taught to recognize and treat certain common diseases and to give health education that includes nutrition, contraception, and sanitation. They receive an initial capital input from the government for supplies to be sold at profit.³

B. SOURCES ON INDIGENOUS HEALTH PRACTICES IN AFGHANISTAN

B.1. AID-supported Reports

AID is to be commended for bringing to light information about indigenous practitioners and village health-seeking behavior. The major source of information on these two intimately linked topics is a body of reports produced by AID-sponsored research and a

¹ Health Sector Assessment Paper, USAID/Kabul, 1978; Area Handbook for Afghanistan (Smith et al.) 1973: 129.

² Management Sciences for Health 1977.

³ Health Sector Assessment Paper.

health sector assessment paper produced by the AID Mission in Kabul.¹ These reports are exemplary of the kind of studies that should precede, or at least accompany, all AID-health programming in order for the Agency to successfully carry out the Congressional mandate.

B.2. Other Sources

Only the work of Louis Dupree and Ludolph Fischer can be considered substantive sources on the subject although some information is scattered throughout other items listed here.

For this reason AID personnel would profit from consulting the original versions of the AID-supported work, and only an outline of the material therein is presented below.

C. INDIGENOUS ETIOLOGY

C.1. Supernatural Causation

Patterns of supernatural causation in Afghanistan seem similar to those described in other survey countries. The evil eye does not appear so fearful a threat as in North Africa and the Levant, however, "God's will" remains a powerful explanatory factor.²

C.2. Natural Causation³

Ill-health is attributed to natural forces according to several co-existing medical theories. Afghanistan is uniquely different from the other six countries surveyed here in its plurality of formal indigenous medical systems.

a) Greco-Arabic Medicine. This is called Dawa-Unani by Afghans. It derives from the Greek Hippocratic system adopted by the Arabs and imported to Afghanistan perhaps 1500 years ago and builds on the classic Arab medical theories of Ibn Sina, Razi, and others. It is a medical "great tradition" meaning that it is formally taught in schools and practiced by literate professionals.

b) Ayurvedic medicine. Ayurveda ("the science of living to a ripe age") is the classical medical system of India and also widely followed in Afghanistan. It too is a "great tradition" perpetuated in schools and by literate practitioners.

¹ The reports are those listed in the Bibliography under Afghan Demographic Studies, Hunte, Kerr, Management Sciences for Health, Macey and Pakmal.

² See also Fischer (1974) and Canfield (1976).

³ This section derives largely from Macey, Hunte, and Kamal--(1975) and Hunte (1976).

c) Hot and cold. The humoral concept of hot versus cold permeates the theories and remedies of Afghan traditional medicine. "Hot" and "cold" have little to do with temperature as measurable by a thermometer but rather with the intrinsic nature of a person or thing. Women are said, for example, to be "hotter" than men. One prevents illness by maintaining an internal balance of "hot" and "cold." Certain illnesses are considered "hot"—in which case they must be treated with "cold" foods, herbs, and medicines to restore the balance. The same principle holds for illnesses that are "cold."

d) Germ theory. The practitioner called hakims also know about germs and say they are what make people sick.

D. INDIGENOUS PRACTITIONERS¹

D.1. Dalaks (Barbers)

The dalak is referred to as a jack-of-all-trades who provides valuable health services to his community. In addition to barbering, these include the following: circumcising, blood-letting, tooth-pulling, treatment of khurasak (wheezing, possibly diphtheria) curative burning (cauterization), cooking (at weddings and funerals and preparing khairat, food given in the name of God), and town-crying (informing people about weddings and funerals by going house to house).

The dalak often inherits his profession but may also learn it through apprenticeship to an unrelated dalak. He treats patients in their homes in exchange for payment which varies in amount with the socioeconomic circumstances of the family.

It is suggested that dalaks' services could be improved by literacy training and a basic course in health and hygiene which could be conducted by the Ministry of Public Health.

D.2. Dais (Traditional Birth Attendant)²

Afghan midwives are proud of their inherited profession and realize its vital importance. The greatest percentage of Afghan infants are delivered by dais. They perform their work from economic necessity but also benefit from the religious merit it confers upon them.

Maternal services generally begin with pre-natal care which may include abdominal massage, dietary advice, and miscarriage

¹ This section is based on the outstanding report by Macey, Hunte, and Kariab (1975).

² See also Hunte 1976a.

prevention advice. Some dais remain in the woman's home for a few days after delivery. The dai is also sought out for advice on indigenous methods of fertility regulation—usually to induce fertility but in other cases to induce abortions.

The dai does not request payment from her clientele but an amount understood as appropriate for the community is usually paid. This is generally only about one-fifth the fee charged by a physician or nurse-midwife. Some dais will deliver for free for those too poor to pay.

The dai's role in the community is judged to make her an ideal disseminator of new information and ideas. Dais occupy crucial positions in the female networks of their communities and are accustomed to diffusing health-related information. Usually dais are related to or closely acquainted with the women they serve. They are also extremely perceptive in their treatment and able to intimately interpret social and economic factors.

D.3. Holy-Men: Mullah, Sayeeds, Malangs

This category of practitioners is said to deal with psychological problems. One or more mullahs are found in every village; they are religious leaders who play an important role in prevention and cure. Mullahs are said to be most effective in treating emotional problems, nervousness, anxiety, mental illness, and illnesses due to jinn and other evil spirits. The major form of treatment used by mullahs and sayeeds is making and prescribing amulets (tawiz).

a) Tawiz-makers. These literate persons have studied in mosque schools and may have taken several-year courses in amulet-writing. Many inherit the role and most enjoy high status in their home communities and even beyond. Amulets are usually prescribed for the following purposes: illness, male impotence, inducing or inhibiting pregnancy, influencing relations between two people, and (especially among children and pregnant women) protection from jinn. Inscriptions written on them are frequently the specific verses from the Quran that concern health. The cost of an amulet depends on its purpose. If the patient is very poor the tawiz-maker will accept whatever sum can be offered.

b) Shrines.¹ In Afghanistan as elsewhere in the Muslim world, veneration of local saints, though forbidden by Islam, is common. Ziarat (saints' shrines) dot the Afghan landscape. Pilgrims flock to ziarat to ask a pir, khwajah, or other type of

¹ On shrines and associated practices, see especially Dupree 1976b.

saint to intercede with God for special favors. Shrines, like practitioners, are often specialized. One is famed for curing mental disorders, especially female hysteria. Another is known for curing bites of mad dogs. Still others draw women seeking cures for infertility.

Shrine caretakers (notawali) must also be classed among persons rural Afghans turn to for health problems. They watch over the shrines and usually sell tawiz for preventing misfortune and for inducing all sorts of desired future results.

c) Malang. These are wandering holy-men whom Afghans believe "touched by God." Some go naked, moving with the season. Malang are fed, honored, and sometimes held in awe by the rural poor. They symbolize the interpersonal tensions that often smolder as group pressure suppresses their expression in the tightly-knit Afghan peasant society. In the peasants' view, no one willingly leaves the protective web of relationships of kin and village. Therefore the malang must have been "touched by the hand of God" and should be venerated. When a malang dies, villagers build a qiblat around his tomb and he becomes another local saint.

P.4. Atars (Herbalists)

An atar is a shopkeeper who sells traditional medicines and understands the medicinal properties of herbs. These are Afghanistan's most common form of medicine and thus the atars perform a major health role.

Herbs are usually gathered or purchased by others and brought to the atar. Some come from the Arab countries. Usually atars neither diagnose nor prescribe, but derive their main income from sales. If a customer cannot afford to pay for a medicine the atar usually offers it free of charge. The atar feels he is compensated by receiving religious merit (sawab) for this. Atars are much respected by the public and their medicines purchased even by well-educated urbanites.

Atars belong to the shopkeeper class and their working places are usually small shops in the bazaar. Most atars begin as apprentices in their fathers' shops at a very young age. The majority are illiterate but able to speak many languages. Many are Indian.

P.5. Wise women

Nothing is discussed about this category of health adviser.

D.6. Shikastahand (Bonesetters)

Given that physicians and hospitals are few and far between, the bonesetters perform valuable services. They are usually respected members of the community and said to have a high rate of success in correctly setting broken bones. In addition, bonesetters reduce dislocations and treat back pain (by massage and pressure), sciatica, and general body pain.

Bonesetters are usually older men who have learned their skills through experience. The specialization is usually not inherited but rather is thrust upon them by a rural community's need for bone repair. Often bonesetters have other occupations, such as farming or shopkeeping, from which they make a living. Their services as a health practitioner are performed for religious merit. It is recommended that the bonesetters be given basic courses in first aid, health, hygiene, and literacy that could be sponsored by the Ministry of Public Health.¹

D.7. Hakims

Hakims are highly trained medical practitioners who use procedures and medicines from both the Indian Ayurvedic school and from the Greco-Arabic tradition. Hakims are literate and obtain their education as apprentices to a father or uncle and from mosque schools or public elementary schools. Some have also studied at special schools for hakims in India and Pakistan. Being a hakim is a full-time life-long profession.

A hakim is usually found in a small shop filled with medicinal preparations. These are herbal, chemical, and mineral. The hakim prepares them or may give a patient a prescription to be filled by the atar. Many medical texts, some very ancient, are studied and carefully preserved by the hakims. They are written in Arabic, Farsi, or Urdu. The hakims themselves are multilingual since their patients come from a wide variety of ethnic backgrounds. Both native Muslims and Indian Sikhs become hakims.

Hakims are found primarily in cities and bazaar towns. While some urban elite consult them, they are an especially important resource for the low-income urban population who cannot afford the prohibitively high fees charged by Western-type physicians. The hakims' medicinal preparations, too, are much less expensive than those sold by pharmacies. In addition, treatments prescribed by hakims frequently includes dietary advice as well. As stated above, hakims know about germs as disease agents.

¹ Macey, Hunte, and Kaniab 1975: 29. The remainder of this part (Afghanistan) is extrapolated largely from this source.

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E. STRATEGIES OF RESORT

"Modern" medicine in Afghanistan has by no means displaced indigenous healing but merely expanded the range of options. It appears that few Afghans confine themselves exclusively to modern medicine since even the most educated and wealthy strata are occasionally known to seek herbal preparations and advise from the ata or hakim. It is said that these medicines do not have the negative side-effects of Western-type pharmaceuticals.

Most rural Afghans, however, cannot afford and do not normally have access to physicians but continue to rely primarily on indigenous health practitioners. Some Afghans complain that doctors do not have enough time to give a patient good individual treatment anyway. Many others simply "do not trust" modern medicine.

Women, more than men, depend more heavily on the traditional sources. Mullahs and shrines are the most popular sources of aid. Many women also prefer to visit a hakim rather than "modern" physicians because with the former they may remain in chadri (purdah) while the latter ask them to disrobe. Women do, however, take their children to modern physicians.

a) Referral. There is frequent referral from one category of indigenous practitioner to another. They also refer patients to modern physicians when they recognize problems they cannot successfully treat. Some indigenous practitioners also consult modern physicians when they themselves develop such problems. There is little referral, however, from the modern to the traditional sector.

b) Contrasts between "traditional" and "modern." It is apparent that the services and medicines of the urban-trained Western-type health practitioners are beyond the financial means of the Afghan poor majority. Other factors also appear to clearly set the latter practitioners apart from their indigenous counterparts.

First, Western-type practitioners spend relatively little time with their patients and apparently show them little personal concern. Second, they do not participate reciprocally in the local community's referral system. Third, they do not conform to established fee-for-service patterns. The Afghan sources show clearly that the rural population, even while desperately poor, still expects and is willing to pay for services and medicines rendered. But they are accustomed to doing so on a sliding scale. Indigenous practitioners likewise are accustomed to receiving their sliding-scale fees. They remain motivated since what they do not receive in money they receive in "merit" for serving the public through their profession.

c) Implications for other countries. These findings probably accurately present the situation in the other Near East countries where researchers have not yet so carefully investigated the motivations and expectations of the rural and urban poor toward health care.

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