

AN EVALUATION OF THE
AFGHANISTAN FAMILY GUIDANCE
ASSOCIATION CLINIC EXPANSION

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EVALUATION REPORT ON THE
AFGHANISTAN FAMILY GUIDANCE ASSOCIATION
CLINIC EXPANSION

I. Introduction and Background

Afghanistan, with a land area about the size of Texas, is classified by the United Nations as one of the 25 relatively least developed countries in the world. A substantial part of the rural trade is still conducted on a barter basis.

Until the State University of New York (SUNY) demographic study was completed in 1974, the Government of Afghanistan (GOA) estimated its population to be in excess of 19 million. The SUNY study reported 10.4 million settled population and 1.1 million nomads. The annual growth rate is 2.3 percent. Approximately 88 percent of the population live in rural areas. Roads to large numbers of rural villages from provincial headquarters are non-existent.

There was literally no organized family planning program in the country until the Afghanistan Family Guidance Association (AFGA) was organized in 1968, and became operational the next year. AFGA is a voluntary organization affiliated with the International Planned Parenthood Association (IPPF). AID has provided contraceptives to the GOA, Ministry of Public Health (MPH), which in turn has supplied AFGA from the latter's beginning. AID made substantial grants to AFGA in 1975 and 1976.

In the nine years since its beginning, AFHA has earned growing acceptance and slow but steady rises in numbers of new acceptors and revisits. Dr. Ronald O'Connor, President of Management Science for Health, who is well acquainted with health and family planning developments and problems in Afghanistan, believes that AFGA paved the way for a contraceptive distribution function in the MPH's Basic Health Centers and Village Health Worker pilot project. (See Appendix E for tables showing (1) visits by method, (2) by type of visit and method, (3) a summary table on clinic visits by acceptors-all methods.)

Today AFGA operates family guidance clinics in every province except two in the country, along with nine in Kabul. In accordance with government policy, all clinic services are free.

This is one of the most difficult environments in the world in which to carry out a family planning program. There is an extreme shortage of physicians, more than 80 percent of whom are in Kabul. Nurses are in even shorter supply. Barriers to recruiting new acceptors include some opposition from Muslim leaders, lack of educational opportunities for women, the tradition of large families, partly as a means of social security in old age, the realization that if a family has ten children, probably no more than five will survive past age five, and the desire of most families to have at least two or three sons.

While the GOA believes it cannot issue a national family planning policy and have key leaders articulate support of family planning to the population, the government clearly does favor a national family planning program. The Minister of Health was one of the nine founders of AFGA and served as its first Secretary-General. He asked AFGA to expand its clinic program from a total of 19 in 1974, including nine Kabul, so that there would be one in each of the 26 provinces.

Under the able and driving leadership of the current Secretary-General, Madame Nawaz, AFGA has carried forward with considerable success during the past two years of the clinic physical and staff expansion program. She and her staff have been successful in recruiting a generally high calibre staff to operate the clinics and have begun to reach into provincial towns and the neighboring countryside to contact women in the fertile age range as potential acceptors.

II. PROJECT AND GOAL PURPOSES

A. PROJECT PURPOSES

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

B. ASSUMPTION RELATED TO PROJECT PURPOSE

1. GOA will continue to sanction AFGA operations.

The GOA, through the Ministry of Public Health, has continued to support the AFGA operations and assist in its expansion by providing from its own staff doctors and nurse-midwives, providing space in hospitals to establish the clinics, allowing AFGA imports to be duty free and lending encouragement to the Secretary-General and her staff. The GOA's Radio Afghanistan is providing 30 minutes of air time each week for national broadcasts by AFGA. (Editorial Comment. In mid-July some of the GOA's top generals participated in a ceremony to open the first family planning clinic within a military facility.)

2. Qualified people will be retained.

According to the Secretary-General, there has been little turnover in staff under this clinic expansion project. Our own interviews and observations tended to support this statement.

3. Continued funding through IPPF or other donors will be available.

IPPF has continued to help fund the project. It contributed as follows: (CY) 1975, \$125,000; 1976, \$180,000; 1977, \$180,000. The IPPF office in London has told Dr. Thomas, USAID Population Officer, that they intend to continue funding assistance to the project for the next few years. The team learned that IPPF has committed \$270,000 for CY 1978.

C. STATEMENT OF GOAL

This project is justified on the basis that it is designed to contribute to the broader GOA goal of achieving a population growth rate which is compatible

with the social and economic development progress of Afghanistan. The goal statement is USAID's, since the GOA has no public goal on population.

D. MEASURE OF GOAL ACHIEVEMENT

After a period of approximately 24 months of project operations, much of which time has been spent in getting the additional clinics physically established, equipped, staffed and in operation, it is premature to assess the impact the expanded clinics have on the goal. Some of the latest clinics to be established under this project have been in operation less than ten months.

There exists in Afghanistan today no statistical data to indicate the change in rate of natural increase of population since this project supports became active in the summer of 1975. This project supports the only family planning activity of any kind at this time, though some contraception distribution work is just getting underway in some Basic Health Centers and about 15 pilot Village Health Worker locations.

The most definitive indicator of this project's success in contributing to the larger USAID-defined goal is the rising number of new acceptors each year. This report notes elsewhere that in CY 1976 total clinic visits increased by approximately 70 percent compared with CY 1974, shortly before AID became involved in supporting the AFGA clinic expansion program. To put the matter in somewhat sharper perspective regarding the project's contribution to goal achievement, the entire target population of the expanded clinic program is not more than 20 percent of the nation's fertile age population.

III. PURPOSE OF EVALUATION AND METHODOLOGY

A. PURPOSE OF EVALUATION

The purpose of this evaluation is to determine the extent to which the Afghanistan Family Guidance Association (AFGA), the grantee, has achieved the expectations of this project as detailed in the 1975 revised Project Paper. The evaluation seeks to measure success in terms of achievement of both specific outputs and conditions which are expected to exist at the end of the project funding period. Another purpose of the evaluation is to make a recommendation regarding the future of the project: whether it should continue in its present or some other form or be discontinued.

Using as a base point of reference the logframe prepared by the USAID as part of the Project Proposal, the evaluation team prepared and followed throughout the course of its work an evaluation design. (See Appendix B).

After briefings in Washington by appropriate officials, two of the team members proceeded to Afghanistan where the USAID and AFGA members joined to form the four-person evaluation team. After initial meetings with USAID officials, the team spent approximately two weeks conferring with various AFGA, GOA and USAID representatives, and with Management Science for Health and University of California, Santa Cruz, contract team members.

During part of the same two weeks, the American team members, accompanied by an Afghan lady physician from AFGA, visited six different clinics located in six northern provinces. Findings and recommendations were a product of joint discussions by all four of the team members. They were, at USAID's request, discussed with the Secretary-General of AFGA and USAID representatives prior to the departure of the consultants from the country.

IV. SUMMARY OF FINDINGS AND RECOMMENDATIONS

This project marks the first effort in Afghanistan--made at the request of the Minister of Public Health--to provide family planning services on a nation-wide basis. Despite all the cultural, religious, economic and geographic barriers to establishing a family planning program in this country, the experience of AFGA during the past few years has demonstrated clearly that, as in other parts of the world, there are many women who, often with their husbands' agreement, want to space and limit their families.

In carrying out this expansion, AFGA has sought and obtained cooperation from the Ministry of Public Health (MPH) in securing clinic space in provincial hospitals in all but four provinces, and in getting GOA's doctors and nurse-midwives assigned full-time or part-time in most provinces. Because of the even greater shortage of nurse-midwives than doctors in Afghanistan, only 75 percent of the clinics have nurse-midwives full-time. There are three part-time nurse-midwives.

AFGA has moved vigorously to renovate newly assigned or leased clinic spaces. Without exception, those visited by the evaluation team look better than hospital facilities, are adequately equipped and, with few exceptions, fully staffed. AFGA has essentially achieved its basic clinic expansion purposes outlined in the project proposal approved by AID in March, 1975. A period of at least two or three years is clearly needed to consolidate this expansion activity and strengthen staff capability.

One main area requiring special attention by the Secretary-General and her headquarters staff is to review the several important gaps in the statistical reporting system to permit better assessment of the dropout rate and to have the necessary information to take prompt action on actual or incipient dropouts.

Three other tasks requiring special headquarters attention are to (1) build the Training Center staff so it is capable of helping AFGA resource people utilize proven training techniques to make more effective clearly needed continuing in-service training of clinic staffs, (2) strengthen a basically fine Information and Education (I&E) program by shifting the emphasis on booklets, flip charts and similar materials to a more verbal approach, since the great majority of village women are illiterate, (3) establish a formal evaluation system with a built-in feedback arrangement.

One important change needed in the network of clinics across the country is to reorganize staffing assignments to make the nurse-midwife the clinic supervisor. The physicians, who usually spend most of their time over in the hospitals anyway, should be utilized as part-time consultants to the clinic staff on special problems. A second change which should increase sharply the effectiveness of winning over new acceptors is to broaden the presently narrow-based clinic services to provide some simple prenatal and post-partum care service.

The project is designed to reach a geographic target audience of no more than 20 percent of the nation's potential acceptors. Therefore, for the GOA to eventually reach the majority of fertile age women, it will be necessary to coordinate closely the AFGA program with other activities; such as the approximately 110 Basic Health Centers, some of which are just beginning to distribute contraceptives, and the Village Health Worker pilot project, which also has a contraceptive distribution element. Meantime, AFGA has an excellent opportunity to set national standards of performance for family planning acceptor recruitment and record keeping tied to maternal and child health care. The patterns and standards set by AFGA hopefully will be transferred, along with AFGA clinic staffs and facilities, to the MPH as a nucleus for a comprehensive nation-wide family planning program.

V. FINDINGS AND RECOMMENDATIONS

1. FINDING

AFGA is currently the only organization in Afghanistan carrying out a national family planning program. While the government believes it cannot at this time issue a national family planning policy and articulate it to the nation through its top leadership, the GOA clearly supports family planning. The Ministry of Public Health is making contributions, in-kind, to the AFGA.

The GOA has, for example, made land available to AFGA, which provides a modest source of annual income, and the MPH has detailed its own staff physicians and nurse-midwives to clinic staffs throughout the country.

There is little evidence that commercial distribution of contraceptives reaches more than a very small number of families, mostly the educated, upper economic class. In this environment where most of the rural trade is on a barter basis, there is little likelihood that village women or men are going to seek contraceptives from a commercial source.

Within this environment, AFGA has been able, in the past two years, to increase the number of clinic visits, including new acceptors and revisits: approximately 83,000 in CY 1976 compared with about 49,000 in 1974, a rise of approximately 70 percent.

RECOMMENDATIONS

- (1) That AID continue to support the AFGA Clinic Project for the next two to three years. Each annual grant of funds by AID should, however, be keyed to and conditioned upon AFGA's carrying out the evaluation recommendations on a schedule to be agreed upon by AFGA, USAID and AID/W.
- (2) That continued support be based upon the reassurance by GOA that it still plans to absorb AFGA's clinics within the Ministry of Public Health.
- (3) The GOA should be informed that the USAID and AID/W take a strong position that a follow-on grant be tied to the assumption by GOA of a substantial increase in its in-kind contribution; such as increased radio time, collaborative training of staff, clinical supplies furnished, and perhaps some additional government land being made available for rental income by AFGA.

2. FINDING

Although AFGA keeps an elaborate system of clinic registers, patient records, socio-demographic data sheets, family guide visiting records and coupon system for acceptors, only an absolute minimum of information is taken from this data and later used for planning clinic work, including acceptor follow-up.

AFGA headquarters and clinic staff know only how many acceptors are recruited during the previous month for each contraceptive method, and the total number of visits made to each clinic. AFGA has no idea whether new acceptors ever take the first month's cycle or use the condoms. They do not know how many acceptors drop out or how many continue after the initial visit to the clinic. No clinic is aware of the work being done by the total AFGA clinic program, nor is it able to compare itself with other individual clinics.

RECOMMENDATION

It is imperative to revise the statistical reporting system to provide information on continuation and prevalence rates as quickly as possible.

Statistical data on continuation and prevalence rates is needed urgently both by AFGA's Medical Director of Clinics and by each clinic supervisor in order to know how effective the program is. This type of information is needed both in Kabul and in the provincial clinics for program management purposes. Clinic supervisors can use it to insure that family guides revisit acceptors on a timely basis, and thus be able to help the acceptor correct side effects and prevent dropouts. Headquarters can use it to spot clinics which do not seem to be carrying out a vigorous acceptor follow-up program. The apparent loss of new acceptors is high.

3. FINDING

The AFGA clinic expansion program now has reached the point where expanded facilities and staff are in place. The next two to three years should be looked upon as a period of consolidation and for strengthening clinic staff capability to gain and retain new acceptors. The present narrow scope of clinic services is seen as a limiting factor in trying to conduct most effective outreach work into the provincial towns, villages and into the hospital waiting rooms.

RECOMMENDATION

AFGA should expand its clinical activities into a more comprehensive family planning program to include some preventive MCH services. Expanded services should include some simple and modest scale pre-natal care, including iron and vitamin supplements and, perhaps, tetanus shots for expectant mothers.

Simple post-partum care should include, along with contraceptives supply and iron and vitamin supplements, well-child care with appropriate immunization and attention to growth and development. Consideration should be given to providing emergency care for infants with diarrhea or respiratory problems, while referring to hospitals problems requiring curative care.

4. FINDING

Little professional quality training leadership is being provided for AFGA by the Training Center. The Training Center role, as we understand it, appears to be little more than one of "scheduling".

There is need for a strong training staff to work with key AFGA officers to identify the most important training needs and to get the necessary training programs organized. This training staff will need to teach those AFGA and other resource people who will have to help design, and will be the ones to conduct specialized courses, the most important elements of both how to organize course material to make the teaching of it most effective, and, secondly, how to get ideas across to the students.

The evaluation team believes there is a need for in-service training courses to help upgrade performance of doctors, nurse-midwives family guides and supporting clinic staffs. Family guides, particularly, need more training related to expanded clinic services, in the best methods of contacting target groups and handling follow-up work with acceptors. Nurse-midwives will need training related to expanded clinic services and clinic supervision.

RECOMMENDATIONS

- (1) The vacant position of Assistant Director, Training Center, should be filled as early as possible with a professional trainer. If none is available, then a person who appears to have good potential to become one should be selected and provided with six to twelve

months of training. Hopefully the training could be arranged locally so that others on the staff could benefit from a local training source.

- (2) AFGA should develop comprehensive training courses for nurse-midwives, family guides and physicians, based on written job responsibilities of each group. Emphasis must be on clinical skills, including appropriate skills in communicating with fertile age range women. AFGA training should relate, to the maximum extent reasonable, to parallel Ministry of Health training classes.
- (3) As a basis for preparing such training courses for various main types of workers, the AFGA Training Center should take the leadership in helping AFGA to develop a Clinic Procedure Manual. This manual should describe, step-by-step, how to carry out the main tasks of family guides, nurse-midwives and physician. For example, a detailed procedure should be written for developing the home visiting programs of each clinic to assure that all geographic areas are covered, that each household is provided enough visits for proper introduction of family guidance messages and services, and that methodology for recording the sequential visits enable complete follow through.

The manual should include chapters on the selection and management of patients for specific contraceptive devices, elementary services in well-child care and immunization, basic services in pre-natal and post-partum care, basic first aid for mothers and babies with respiratory and gastro-intestinal problems. Course material should be updated annually.

- (4) Full use should be made of visual aids, using the I & E staff as resource people.

5. FINDING

While the AFGA Information & Education staff are able and enthusiastic, and are turning out excellent materials (posters, flip charts, booklets), not enough of the product is in use at the grass root level. The evaluation team found some family guides using one set of black and white flip charts which appear to be too technical and too dependent upon the written word for a highly non-literate rural audience.

The I & E office arranges for the weekly production of two 15-minute national radio shows. The scripts, in the form of dialogues between villagers, use the language of village people. AFGA is trying to arrange with Radio Afghanistan to double its radio time. Radio is one of the best media for reaching village people. A study showed that nearly two-thirds of the village women surveyed listened to radio broadcasts at least five times a week.

One of the simplest forms of information was seen lacking in the provinces we visited. While there were written signs for the non-literate population, no advertisements displayed any visual symbol of the organization.

RECOMMENDATIONS

- (1) The I & E program should de-emphasize even further the use of the written word in the preparation of flip charts, posters, picture booklets.
- (2) AFGA headquarters staff visiting the clinics should insure that the materials are in full use both within the clinic buildings and by family guides in outreach work.
- (3) The I & E office should advise and assist the Training Center to develop audio-visual aids for use in future training programs.
- (4) I & E should establish a clinic locator system, involving the use of pointer signs and visual symbols for the rural women.

6. FINDING

In the clinics the talents of the nurse-midwives need to be used more effectively, for the nurse-midwife is the key link between doctors, family guides and acceptors. She is trained to establish a rapport and make the client feel at ease. Many physicians spend only one-and-a-half to two hours a day at the clinics. The rest of their time is devoted to curative work at the hospitals. After hours they arry on private medical practices.

Physicians have neither the time nor the inclination to sit for 20 to 30 minutes or more talking with a potential acceptor, listening to her medical history, asking pertinent questions, gradually gaining her confidence

so that she can be persuaded to become an acceptor. Furthermore, the vast majority of physician in provincial clinics are male, while female potential acceptors want to be examined only by a female clinic worker.

RECOMMENDATION

Because most AFGA clinic services are preventive and can be handled well by a nurse-midwife, and because physicians are urgently needed for serious medical problems, we recommend that the nurse-midwife in each clinic where there is a part-time doctor should become the clinic supervisor, responsible for all client services. Physicians no longer should be a central part of the clinic staff. Instead, contracts should be made with selected hospital physicians to serve as part-time consultants to the clinics, with the stipulation that they be available at least a minimum period of time each day. Wherever there are full-time doctors on duty now, AFGA should examine the feasibility of shifting them to a part-time consultant status.

The evaluation team believes that restructuring the clinic staff so that it is nurse-midwife oriented will provide more effective, full-time clinic supervision, which is now much needed. It will provide a much more receptive environment for the potential acceptor who is referred to the clinic, and thus should contribute importantly to helping increase the volume of new acceptors and improving continuation rates.

7. FINDING

While AFGA has sent two different supervisory teams to provincial clinics for inspection and corrective action purposes during the past year, it has no established system for evaluating overall headquarters and clinic operations. The time has come to set up a permanent evaluation system within AFGA. Both the organization chart and the grant agreement provide for an evaluation specialist within the Clinic Information Analysis Unit, but the position has not been filled.

RECOMMENDATION

AFGA should strengthen its evaluation process by establishing an evaluation position within the Clinic Information Analysis Unit. Main responsibilities of the evaluation officer should be to: (1) provide leadership within AFGA in creating an evaluation system, (2) act as coordinator in bringing together AFGA staff members selected to help conduct evaluations

on a regular schedule, (3) chair, or assist the chairman, of evaluation review meetings to draw out the most important findings and recommendations, (5) serve as staff person to insure that useful action recommendations are promptly fed back into the program to help improve both AFGA headquarters and clinic operations.

VI. END OF PROJECT CONDITIONS

1. Rising numbers of new acceptors.

Targets:

<u>CY 75</u>	<u>CY 76</u>	<u>CY 77</u>
17,000	28,000	31,000

PROGRESS TO DATE

13,000	17,000	4,300 (first qtr. of yr.)
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During this expansion the planned targets were not met because it appears that they were unrealistically high for the startup period. In CY 1974, before USAID direct involvement, there were 11,000 new acceptors and 38,000 revisits, for a total of 49,000 visits.

In CY 1975 total visits were 65,500, thus 33 percent higher than in previous year. In CY 1976, the 83,000 total visits were 27 percent higher than in 1975. New acceptors increased by 18 percent in 1975 compared with 1974. In 1976 they were 30 percent higher than the previous year. This indicates a substantial increase in activity of the clinic system. Figures for the first quarter, 1977 tell little because during January-March each year heavy snows and frigid weather slow activity considerably in many parts of the country.

RECOMMENDATION

AFGA should strengthen its outreach effectiveness through the family guides by taking action on the recommendations contained in Part V of this report. It should be particularly helpful to AFGA in its efforts to increase numbers of acceptors to have better statistical data on dropout rates as a basis for following up on faltering acceptors, and to reorganize the clinic operations around the nurse-midwife who will be able to provide, for the first time, daily supervision over the family guides.

Follow-on training to upgrade family guides in ways to improve outreach effectiveness, along with a slight broadening of their range of services to potential acceptors, should contribute to increasing numbers of new acceptors and retaining earlier ones.

2. A total of 35 clinics are in operation.

PROGRESS TO DATE

There are now 32 full-time and four part-time satellite clinics operating in Afghanistan. Most of these clinics are fully staffed and all are furnished and equipped to carry out AFGA clinic functions.

RECOMMENDATION

AID should help AFGA to consolidate and strengthen the present system in order that the clinics and headquarters become more efficient by building on the already established base created during the past two years. Our specific recommendations on ways to coordinate and strengthen the present system are contained in our Summary of Findings and Recommendations. We recommend against the establishment of additional clinics.

3. Clinics staffed with 27 doctors, 35 nurse-midwives and 140 family guides.

PROGRESS TO DATE

These targets have been substantially achieved. Presently a total of 30 physicians are on the payroll; 19 of whom are full-time and 11 are part-time. There are 27 nurse-midwives; 24 of whom are full-time and three part-time. There are 137 family guides working throughout the clinic and headquarters system.

RECOMMENDATION

That AFGA try to recruit more nurse-midwives so that each clinic will have one well qualified, full-time nurse-midwife. When possible AFGA should use doctors as part-time consultants in clinics that are physically within the provincial hospital.

4. Family guides working as prescribers and suppliers of contraceptives and delivering a basic MCH service.

PROGRESS TO DATE

This project design element is not being carried out in most clinics. Clinic supervisors have reported, on the other hand, that many village wives will not come into the clinics, both because of travel difficulties and because their husbands will not allow them to go outside the home.

RECOMMENDATION

The AFGA Secretary-General and key members of her staff should assure that all clinic physicians, nurse-midwives and family guides clearly understand that AFGA policy (supported by MPH) of having family guides serve as "prescribers and suppliers" of contraceptives is in full force and effect, and all staff members are to cooperate fully to insure that this policy is carried out. This policy position should be further underscored during in-service training sessions for clinic staffs.

As earlier recommended, a more intensive training program will allow the family guides to acquire more skills related to increased MCH services for the target population.

5. Family guide services extending 10-15 kilometers around each clinic.

PROGRESS TO DATE

Outreach work by family guides is usually limited to the walking distance (five-six km) from the clinics. In a few cases where public transportation is readily available or the clinic has its own vehicle, outreach work may cover a radius of 50 km. No woman in Afghanistan ever rides a horse, and cars are expensive to operate, often lacking adequate repair facilities in the countryside. Roads to many villages are non-existent.

RECOMMENDATION

Until an organized and methodical approach is developed for home visiting and outreach services, no increased investment in transportation is recommended. A study should be made of the feasibility of equipping some family guides with bicycles on a pilot basis for village travel where other forms of transportation are not available. Since the family guides always travel in pairs, there should be no social barrier to prevent this form of travel. With bicycles, they should be able to range outward up to the project target distances of 10-15 km a day and be able to cover the provincial town streets much more quickly.

VII. OUTPUTS

1. Available family guidance services from the 16 new clinics to be functioning in provinces without services at present and services available to larger number of people in area of existing clinics.

PROGRESS TO DATE

The clinic expansion project target of 16 new clinics rented, renovated, equipped, staffed and operating has been substantially achieved. There are now an additional 13 full-time clinics and four satellite clinics (operating several days a week out from permanent clinics). Two additional satellite clinics are being readied. This will complete project physical expansion activity.

RECOMMENDATION

AID should not support the further physical expansion of the system of AFGA clinics. Further enlargement of the network with AID support should await MPH's assumption of firm responsibility for taking them over as an integral part of GOA's system of health services.

2. An automated client information system producing published monthly, quarterly and yearly reports.

PROGRESS TO DATE

With SUNY/ADS assistance, an automated client information system was installed using the Afghan Business Machines Corp. (ABM) as computer contractor. ABM did not produce reports in a timely fashion (reports were up to six months late). After SUNY's departure, AFGA excerpted some types of data from the automated system and set up a much more modest manual system within the statistics unit. No reporting system presently exists to produce accurate data to help monitor the delivery of services. AFGA headquarters only know how many new acceptors were recruited during the previous period and the total number of visits made to each clinic.

They have no idea whether new acceptors follow through with contraceptive use, or who and how many drop out after the initial clinic visit. Reporting consists of a statistical compilation for each clinic which, in turn, is sent back to the clinic for reproduction on their records.

RECOMMENDATION

AFGA should review its current reports and future reporting needs. With assistance, it should revise its reporting system, field test and install a procedure for follow-up of new acceptors and to provide management with dropout rates, continuation and prevalence data and other information needed for analysis and operational decision making. With the apparent loss of new acceptors quite high, it is imperative that the statistical reporting system provide this information as quickly as possible. Then the reports generated will provide the needed data in Kabul and in the clinics for better delivery and follow-up of AFGA services, and a greater family planning impact on the rural family.

3. An established AFGA training capacity which will train 126 family guides CY 75 63 CY 76 63.

PROGRESS TO DATE

The target goal of 126 trained family guides essentially has been achieved. The selection and initial one-month training of the guides has been accomplished on time with 137 family guides now working throughout the system. Although AFGA has used a wide variety of resource people within and outside the organization to carry out effective training, there is little in the way of an organized system of training today in AFGA. The Assistant Director position has not been filled and the unit lacks professional trainer leadership. There is a need for a strong training staff to work with the teaching people in AFGA to assist in organizing material and getting ideas across to classes.

RECOMMENDATION

The vacant position of Assistant Director, Training Center, needs to be filled as early as possible with a professional trainer. The staff should help develop comprehensive training courses for nurse-midwives, physicians and family skills for each group. A Procedure Manual should be developed for clinic employees. Such a manual should be invaluable as a partial basis for designing training courses, for supervisory purposes in clinics and for individual employees to use as a reference handbook.

VIII. INPUTS

All inputs to this project were provided, with few exceptions, on a timely basis. Where they were not provided, it was because either AFGA, or AFGA and USAID jointly, decided that the items were either not needed or not wanted. The evaluation team learned of no holdups of project activity of any consequence because a donor failed to provide committed inputs.

The MPH has not made available to AFGA (with AFGA paying the salaries) enough nurse-midwives to staff all clinics, but this is due to the severe shortage of nurse-midwives in the country.

USAID provided \$14,000 for short-term consultants, mainly for a base-line study of existing clinics and follow-up on the study. AFGA vetoed the consultants, stating that its previous experience indicated such people are in the country too short a time to be helpful.

USAID granted \$14,000 for commodities, mainly audio-visual equipment for the Training Center. Since the Training Center never progressed beyond a scheduling role, it did not seem timely to acquire them. The problems of the Training Center are discussed elsewhere in this report.

Funds were provided for an automated client reporting system. This was started and later discontinued by AFGA because they did not receive reports within six months of the due date.

The MPH has made available adequate space for clinics in all but four of the provincial hospitals, provided some medicines through the hospital doctors involved with OB-GYN or pediatrics work, made World Food Day program food available, waived import duties on all AFGA imports, provided free radio time nation-wide, and has given AFGA some downtown Kabul property which earns an annual rental of approximately \$20,000 a year. The evaluation team concluded that GOA's limited contributed was provided in a timely manner.

One important shortcoming the evaluation team observed is that the grant system of advance and replenishment upon presentation of expenditure vouchers is not working well. There should have been seven quarterly financial reports which USAID would use, with the supporting vouchers, to replenish funds. So far only three such reports have been submitted.

The USAID inadvertently over-reimbursed AFGA by a substantial amount--well in excess of \$100,000--in September, 1976. Of the \$277,630 USAID has advanced to AFGA to date, the Controller

of USAID reports, AFGA has reported expenditures of only \$138,513. The Controller's office believes AFGA is operating on the over-reimbursement and does not feel a strong pressure to get its reports up to date. Beyond that, there appear to be problems of getting well-trained accountant in AFGA. USIAD believes that the accounting office in AFGA needs considerable assistance in reporting on a timely basis. The USAID Controller's office has sent a representative to the AFGA Controller's office to review the total accounting and financial reporting situation and recommend to AFGA and USAID remedial action.

**PROPOSED
AFGHANISTAN FAMILY GUIDANCE ASSOCIATION
ORGANIZATION CHART**

چارهت تشکيلات پيشنهاد شده انجمن رهنگای خانواده افغانستان

رئيس
PRESIDENT

VICE PRESIDENT
ENGLISH SECRETARY - 1

شبه تحلیلی معلومات کلینیکی
CLINIC INFORMATION ANALYSIS UNIT
ANALYST - 1
STATISTICAL CLERKS - 2

COMPTROLLER
CONTROLER OF BUDGET
ASST. SEC. SECRETARY
ACCOUNTANT/CASHER
RECORDS CLERKS

DIRECTOR OF ADMINISTRATION
D. DIRECTOR
ASST. DIRECTOR
TRANSPORT ASST.
PERSONNEL CLERK
FILES
WATCHMEN
GARDENER
DRIVERS
TYPISTS (FOOD)
STOREKEEPER

MEDICAL DIRECTOR OF CLINICS
DIRECTOR
ASST. DIRECTOR
LABORATORY TECH.
NARUL & PROVINCIAL CLINICS

DIRECTOR OF INFORMATION EDUCATION
DIRECTOR
ASST. DIRECTOR
AUDIO-VISUAL TECH.
CURRICULUM DEVELOPMENT

TRAINING CENTER
ADMINISTRATOR
ASST. ADMINISTRATOR
CLERK
AUDIO-VISUAL TECH.

PROVINCE	DOCTOR	NURSE	FAMILY HEALTH	FROM	DRIVER	GUARD	ACCOUNTING CLERK
1 ZAIRJAN	1	1	4				
2 LAWUPH	1		4				
3 JISALAIKQ	1		4				
4 JHAI BRAID	1		4				
5 ANAI ANANA	1		4				
6 JADA MAHAR	1		4				
7 BIR WAI MAIDAN	1		4				
8 TAIWANI	1		4				
9 MARAFI	1	2	4				
SUB-TOTAL	9	10	36	9	0	9	9

PROVINCIAL CLINICS

PROVINCE	DOCTOR	NURSE	FAMILY HEALTH	FROM	DRIVER	GUARD	ACCOUNTING CLERK
1 GHAZNI	1		4				
2 NANTANAR	1		4				
3 JASHAR JAN	1		4				
4 TERAT	1		4				
5 H. PARAND (PARTIUS)	1		4				
6 ANWAN	1		4				
7 JALILAN	1		4				
8 ANFUZ	1		4				
9 HAZAR	1		4				
10 LOGAR	1		4				
SUB-TOTAL	10	0	40	0	0	0	0

NEW PROVINCIAL CLINICS

PROVINCE	DOCTOR	NURSE	FAMILY HEALTH	FROM	DRIVER	GUARD	ACCOUNTING CLERK
9. KAIKAN	1		4				
2. TALOGAN	1		4				
3. NARAI	1		4				
4. LASHAN	1		4				
5. GJONA SARAN	1		4				
6. BALAT	1		4				
7. MARZAN	1		4				
8. FALA	1		4				
9. ZARJAN	1		4				
10. SATEL	1		4				
11. S. LATTAR	1		4				
12. FACADAN	1		4				
13. KAND	1		4				
14. TIRANDT	1		4				
15. BANTAN	1		4				
16. LOGAR (CONTINUED)	1		4				
SUB-TOTAL	16	0	64	0	0	0	0

APPENDIX A

NEW POSITIONS
15 NEW DOCTORS TO BE FUNDED BY 1977
54 FUNDED BY 1977
16 NEW NURSES TO BE FUNDED BY 1977
82 FUNDED BY 1977
32 FAMILY GUIDANCE CLERKS TO BE FUNDED BY 1977
177 FUNDED BY 1977
503 FAMILY GUIDANCE CLERKS TO BE FUNDED BY 1977
FUNDED BY 1977
FUNDED BY 1977

COUNTRY TOTAL 27 35 140 18 5 24 34

COUNTRY TOTAL 17 11 20 19 5 2 12

PROJECT EVALUATION DESIGN

I. Purpose of Evaluation:

Main purposes will be to (1) determine extent to which tasks assigned in the Project Paper, as revised/authorized 3/3/75, have been carried out satisfactorily, and thus extent to which program goal and project purposes have been achieved; (2) recommend whether this project activity should continue in present or amended form after present grant fund expiration date, September 30, 1977.

II. Project Background

III. Summary of Findings and Recommendations:

Here evaluation team will list and discuss each main finding and recommendation.

IV. Goal:

A. Statement of Goal

GOA undertakes to fund and implement action program to achieve a population growth rate which is compatible with the social and economic development progress in Afghanistan.

B. Measurement of Goal Achievement

1. Rate of natural increase of population.
2. Rate of increase of real income per capita.
3. Size, thrust and funding of GOA programs in 4th and 5th Development Plans.

C. Assumptions:

1. That a process of modernization continues to be a priority in Afghanistan.

V. Project Purpose:

A. Statement of Project Purpose:

Expand the Afghan Family Guidance Association's

system of family planning clinics to a total of 35 and create outreach services for family planning to both males and females.

B. Conditions Expected at End of the Project:

1. Rising numbers of new acceptors:

<u>Targets:</u>	<u>CY '75</u>	<u>CY '76</u>	<u>CY '77</u>
	17,000	28,000	31,000
2. A total of 35 operating clinics.
3. Clinics staffed with 27 Doctors, 35 Nurses, and 140 Family Guides.
4. Family Guides working as prescribers and suppliers of contraceptives, and delivering a basic MCH service.
5. Family Guide services extending 10-15 KM around each clinic.

C. Assumptions Related to Project Purpose:

1. GOA will continue to sanction AFGM operations.
2. Qualified people will be retained.
3. Continued funding through IPPF or other donor will be available.
4. AFGM will arrange to finance costs of its operations increasingly from resources within Afghanistan, either by (a) GOA grants, (b) private contributions, (c) charging for its services, or a combination of these.

VII. Outputs:

1. 16 new clinics functioning in provinces.
2. Published monthly, qtrly and annual reports.
3. 140 Family Guides trained in well-established training unit of AFGA.
4. AFGA headquarters reorganized to adequately support expanded clinic program.
5. ~~For~~ headquarters staff positions recruited and

on the job following initial in-service training.

6. Related to 3 above, newly recruited Family Guides include at least one male FG for each of the 16 new clinics under project which will serve provinces which previously had no clinics.
7. Conclusions will be drawn from experiments in and experience from recruitment of women of varying age groups, marital status, and of proven fertility.
8. Increase radius of travel around clinics with guides following planned routes on a definite schedule.
9. Groups of employed males being contacted.
10. Some physicians trained in clinic work and some Family Guides already on the job given some retraining.
11. Develop adequate client information system in lieu of earlier proposed automated system.

VII. Inputs:

This section will list all U. S. fund contribution broken down to show amount granted to AFGA for each main category in grant agreement. Breakdown will be by CY over life of project.

VIII. Issues:

See attached paper.

IX. Appendices:

1. AFGA organization chart
2. List of officials contacted
3. Participants trained during project life, by country in which trained.

ISSUES PAPER

I. VALIDITY OF PROJECT DESIGN:

1. Have any new conditions or considerations or particular experiences since March, 1975, when this project was approved, caused original project goals, project purposes and targets to be no longer valid or to require important project design revisions? Describe.
2. Since IPPF is already deeply involved in this project, would it make sense to close this out as a bilateral project and channel similar level of funding through IPPF?
3. Project design provides for all outreach work to be carried out through existing 19 clinics and 16 new ones, one in each Provincial headquarters city or town. Family Guides are to do outreach work within 6-9 miles of clinic. Yet 88% of Afghanistan's population is rural. Is such concentration at province headquarters clearly the best approach?

Can clinic base, with outreach workers (FG's) pattern, be used effectively in rural areas in future, or is this approach suitable only for cities and towns?

II. PROJECT OPERATIONS AND IMPACT QUESTIONS:

1. Does lack of a comprehensive base-line study made prior to beginning of this project, hamper AFGA's ability to identify how much increase in new acceptors is directly related to the project and not to other factors such as news and radio stories, word of mouth, information gained from visits to other countries and so on?
2. Has there been any change in national policy on family guidance since the project started? If so, describe.
3. Has it been possible for AFGA to attract a relatively high calibre group of people for Family Guide positions, nurses, physicians? Has there been much turnover?
4. Are Family Guides now on job proving their willingness to go out into hinterlands within 6-9 miles of clinics to do outreach work?
5. How well are such workers received by the villagers?
6. Is there evidence that added role for FG worker of providing basic MCH services is definitely helping pave way for FG to carry out more effectively the work as prescriber and provider/resupplier of contraceptives?

7. Is there any system within AFGA to spot check accuracy of reports of contacts made by Family Guide with target groups?
8. Review entire client reporting system. Is it adequate, effective? Is procedure well understood and in use in each clinic, with appropriate reporting to AFGA headquarters?
9. Do AFGA staff make adequate numbers and kinds of field inspections? Do they concentrate on how effectively FG workers are approaching target audiences, and how they are received? If some problems related to receptivity of villagers, are experienced headquarters staff helping FG workers develop revised approaches to help overcome these problems?
10. What are the internal feedback mechanisms? Are they written down? Understood by the AFGA staff? Are they being followed? Are they adequate?
11. Are contacts by outreach FG workers mainly with groups, or on an individual basis? If they are the latter, what are the prospects for developing effective contacts through groups, such as organizing mothers' clubs, or with any existing women's groups in villages?
12. To what extent is interval evaluation taking place? Is it on an organized and regular basis? Is good feedback taking place?
13. Examine quantity and quality of audio visual aids used in both training work by AFGA, and by clinic staffs and Family Guides. Are such materials appropriate (content, clarity, adopted for target groups' level of education) and effective? How extensively and regularly are they used? Are trainers well-trained?
14. What percent of time do typical AFGA clinic doctor and nurse/midwife spend on MCH? On family guidance? Do these doctors do any private practice work?
15. Of numbers contacted in past two years, what percentage became acceptors? Of acceptors, what percentage became dropouts? Are dropouts contacted on timely basis to determine why they dropped out and try to get them back in program?
16. Are traditional birth attendants consulted with and used as allies in outreach work? Could they be used for satellite outreach work?
17. Is there adequate coordination in country between this project work and other family spacing work carried out by other governmental or private groups?

18. Are there any doctors and nurses not working in AFGA clinics who are being contacted and supplied with contraceptives for their patients who might be interested?
19. To what extent are men being contacted? How many males have been recruited as acceptors in past year? How many of these have continued?
20. Is there adequate delegation of work within AFGA organization? Do clinic doctors and nurses adequately supervise outreach workers?
21. Do AFGA headquarters field supervisors plan and schedule their work so that they make regular monitoring visits? Do they stick to schedules?
22. Where will project be 2-5 years from now if we continue it? Discuss as specifically as possible nature and extent of anticipated further project progress.
23. Are key government and private backers invited to occasional special tours and briefings at AFGA? Discuss.
24. Examine AFGA transportation system for clinic staffs, particularly for outreach workers. Do they walk? Use bicycles? Is transport system adequate? Is TALWEDAR system in effect? If so, comment.
25. Examine storage system for AID-financed supplies, equipment. Is it satisfactory?
26. Examine records system for both funds and materials provided by USAID to AFGA under grant agreement. Are records satisfactory?
27. Examine system of funds and materials audit. Comment.
28. Review any sterilization work now taking place through AFGA. Discuss. Outlook for future.
29. How is GOA/AFGA relationship?
30. Review contraceptives distribution in commercial sector. How extensive and effective is it? What is outlook for future?
31. What are AFGA's attitude and possible plans for future distribution of contraceptives through villages or households?

III. USAID MANAGEMENT:

1. List staff time, by position, U.S. and local, devoted to project in past year. Is this reasonable staffing level?

2. What portion of time does USAID staff spend in field visiting clinics? In AFGA offices?
3. Do any USAID/POP staff have their offices in AFGA or MPH?
4. If project is continued in present or revised form, what staff positions does USAID propose?
5. Do American USAID staff assigned to project speak the language?
6. What monitoring reports have USAID staff prepared? Get copies.
7. Discuss participant follow-up by USAID by AFGA staff. What percent of USAID-funded project participants are now in AFGA program?
8. What specific recommendations have AFGA leadership made for future of this project? What are USAID's specific recommendations related to proposals?
9. What are main ways USAID staff spend their working time? Time in AFGA and field? Time devoted to such main activities as advising and assisting on development of training programs, administrative arrangements, I&E, etc.?

IV. INSTITUTIONALIZATION OF PROJECT PROGRESS:

1. Discuss in specific terms GOA's in-kind contributions to project. Have these been growing? To what extent?
2. Project has helped expand AFGA operations, with concomitant expansion in funding costs. As funding for this project draws to a close, with no firm commitment from GOA to begin taking over operations costs on phased basis, should any continuation of this project thrust after September, 1977 be tied to a firm GOA commitment to take over funding on phased basis?
3. Discuss thoroughly each main cultural barrier. What is being done to overcome each of them? Are ways to overcome these barriers being addressed in outreach work? In I&E work?
4. What I&E work is being carried out by AFGA on regular basis?

PERSONS VISITED ON FIELD TRIP

Kunduz

AFGA Clinic Director: Dr. Abdul Haq
Family Guide: Sediqa
Director of Kunduz Hospital:

Telogan

AFGA Clinic Director: Dr. Farhan
Nurse-Midwife: Ra hela
Family Guides: Nasima, Parwin, Karima

Nazar-I-Sharif

Part-time AFGA Clinic Director: Dr. Sami
Nurse-Midwife: Khowar
Family Guides: Sharifa, Sima, Mobuba, Zirba
Director of Womens Hospital: Dr. Popal
Director of TB Institute: Dr. Abdul Razak

Samangan

Part-time AFGA Clinic Director:
Nurse-Midwife: Gul Sum
Family Guides: Maleqa, Jamila, Shajan, Mazari

Shiberqan

AFGA Clinic Director:
Nurse-Midwife: Tahera
Family Guides: Shiqeba, Anifa, Maleqa, Zelai Kha
Director of Shiberqan Hospital:

Baghlan

Part-time AFGA Clinic Director:
Family Guides;
Nutrition Specialist
Director of Hospital:

PERSONS INTERVIEWED IN KABUL

Afghanistan Family Guidance Association

Mme. Azifa Nawaz, Secretary-General
Dr. Azis Seraj, Director of Clinics
Ms. Afifa Yousufi, Asst. Dir. of Clinics
Dr. Aisha Amir, Director Taimani Clinic
Ms. Aisha Tarzi, Controller
Ms. Mastoora, Director of Statistics
Mr. Nhomat, Director of Information and Education
Supervisory Team: Ms. Omira Noorzai and Family Guides

USAID

Dr. Stephen Thomas, Advisor to AFGA
Ms. Mary Corcoran, Public Health Nursing Advisor
Ms. Ann Richter, Nurse-Midwife Advisor
Mr. Bobby Allen, Acting Controller

Management Sciences for Health

Dr. Ronald O'Connor
Dr. Jerry Russell
Ms. L. Russell
Mr. Peter Cross

CLINIC VISITS BY METHOD

<u>Year & Method</u>	<u>New</u>	<u>Revisit</u>	<u>Total</u>		
<u>1974</u>					
Pill	6,411	24,008	30,419		
Condom	3,430	9,812	13,252		
IUD	1,148	3,991	5,139		
Total	10,989	37,811	48,810		
<u>1975</u>					
				<u>Other Visits</u>	
Pill	6,980	31,532	38,512	Other Methods	328
Condom	4,669	14,475	19,144	Infertility	873
IUD	1,182	4,340	5,522	Other Medical, Info	968
Total	12,831	50,347	63,178		2,169
<u>1976</u>					
				<u>Other Visits</u>	
Pill	9,757	37,370	47,127	Other Methods	768
Condom	5,674	20,264	25,938	Infertility	1,887
IUD	1,283	4,042	5,325	Other Medical, Info	1,671
Total	16,714	61,676	78,390		4,326

CLINIC VISITS BY TYPE AND METHOD

TYPE OF VISIT		1974	1975				Total	1976				Total	1977		
		Total	Quarter					Total	Quarter				Total	Quarter	
			1	2	3	4			1	2	3			4	1
PILL	New	6,411	1,358	2,246	1,575	1,801	6,990	2,243	2,707	2,214	2,593	9,757	2,659		
	Revisit	24,008	6,131	8,018	8,344	9,039	31,532	3,726	10,020	8,965	9,659	37,370	10,237		
	Total	30,419	7,489	10,264	9,919	10,840	38,512	10,969	12,727	11,179	12,252	47,127	12,896		
CONDOM	New	3,430	953	1,576	989	1,151	4,669	1,227	1,441	1,497	1,509	5,674	1,374		
	Revisit	9,812	3,016	3,844	3,190	4,425	14,475	4,492	5,601	5,049	5,122	20,264	5,631		
	Total	13,252	3,969	5,420	4,179	5,576	19,144	5,719	7,042	6,546	6,631	25,938	7,005		
IUD	New	1,148	282	402	278	220	1,182	248	334	345	356	1,283	240		
	Revisit	3,991	918	1,305	1,189	928	4,340	982	1,323	920	817	4,042	964		
	Total	5,139	1,200	1,707	1,467	1,148	5,522	1,230	1,657	1,265	1,173	5,325	1,204		
Other Methods		N/A	N/A	N/A	N/A	N/A	328	274	247	149	98	768	45		
Infertility		N/A	122	254	247	250	873	358	566	507	456	1,887	278		
Medical, Info., etc.		N/A	228	220	309	211	968	360	551	384	376	1,671	564		
Total/Quarter			13,008	17,865	16,121	13,025		18,913	22,790	20,030	20,986		21,992		
Total/Year		48,810					65,347					82,716			
Percent New Acceptors:															
Pill		58%					54%					58%			
Condom		31%					36%					33%			
IUD		10%					9%					7%			

CLINIC VISITS BY ACCEPTORS
(All Methods)

<u>Year</u>	<u>New</u>	<u>Revisits</u>	<u>Total</u>
1969	2,400	5,270	7,670
1970	4,902	7,746	12,648
1971	8,024	16,036	24,060
1972	10,596	28,739	36,335
1973	11,229	31,732	42,961
1974	10,989	37,811	48,810
1975	12,831	50,347	63,178
1976	16,714	61,676	78,390
	<hr/>		<hr/>
Total	77,693		314,086

-APPENDIX F

GRANTS, OBLIGATIONS AND EXPENDITURES

	<u>Obligation</u>	<u>Expenditures</u>	<u>Balance</u>
As of 6/30/77 (Est. 7/1/77)	\$460,000.	\$348,715.*	111,285.
Through End of Grant 9/30/77	-0-	87,300	23,785.
Total	<u>\$460,000</u>	<u>\$436,215.</u>	<u>\$23,785.</u>

*Expenditure reports received to date show expenses of \$138,513.