

A.I.D. EVALUATION SUMMARY - PART I

1. BEFORE FILLING OUT THIS FORM, READ THE ATTACHED INSTRUCTIONS.
2. USE LETTER QUALITY TYPE, NOT "DOT MATRIX" TYPE

IDENTIFICATION DATA

A. Reporting A.I.D. Unit:

O/AID/REP
Mission or AID/W Office Afghanistan
(ES# _____)

B. Was Evaluation Scheduled in Current FY Annual Evaluation Plan?
Yes Stopped Ad Hoc

Evaluation Plan Submission Date: FY 9

C. Evaluation Timing

Interim Final
Ex Post Other

D. Activity or Activities Evaluated (List the following information for project(s) or program(s) evaluated; if not applicable, list title and date of the evaluation report.)

Project No.	Project /Program Title	First PROAG or Equivalent (FY)	Most Recent PACD (Mo/Yr)	Planned LOP Cost (000)	Amount Obligated to Date (000)
306-0200	Health Sector Support Project	9/86	9/89 Extension to 12/31/92 in process	15,700 Extension to 59,700 in process	15,700 Increase by 13,750 in process

ACTIONS

E. Action Decisions Approved By Mission or AID/W Office Director

Action(s) Required

Support and monitor accelerated Area Health Development in four geographical areas.

Continue to train, staff, equip and supply the Basic Health Workers (BHW), and provide retraining and resupply of BHW's as necessary.

Assure sufficient project funding in the first quarter of FY 89 to avoid program implementation delays.

Develop health information and health management systems.

Strengthen the capacity of the Alliance Health Committee (or its successor) to plan and manage an expanded pyramid of health services inside Afghanistan.

Prepare and implement country plans for maternal/child health services (incl. CDD and immunization) and health/nutrition education.

Carry out research activities in: Cost Recovery/Cost Containment, Epidemiological Assessments and Cold Chain Effectiveness.

Name of Officer Responsible for Action
T. Eighmy

Date Action to be Completed
Ongoing

Wm. Oldham

Ongoing

T. Eighmy

1/89

Wm. Oldham

8/89

Wm. Oldham

Ongoing

Wm. Oldham

12/89

Wm. Oldham

Ongoing

(Attach extra sheet if necessary)

APPROVALS

F. Date Of Mission Or AID/W Office Review Of Evaluation:

(Month)

(Day)

(Year)

G. Approvals of Evaluation Summary And Action Decisions:

Name (Typed)	Project/Program Officer	Representative of Borrower/Grantee	Evaluation Officer	Mission or AID/W Office Director
Signature	Thomas Eighmy	William Oldham	John Gunning	Larry Crandall
Date	<i>T. Eighmy</i> 2/28/89	<i>William Oldham</i>		<i>Larry Crandall</i>

ABSTRACT

H. Evaluation Abstract (Do not exceed the space provided)

The project aims to rapidly expand the availability of primary health care and first aid services inside free Afghanistan, and to strengthen the capability of the Seven Party Alliance to plan, organize and manage expanded health care services. The project is being implemented through a Cooperative Agreement with Management Sciences for Health (MSH), a non-profit, U.S.-based health consulting firm. This mid-term assessment was conducted by a USAID team based on a review of project documents, site visits and discussions with PVO, AID/REP and project staff. The purpose was to make recommendations for the direction and expansion of the health sector project in a post-war Afghanistan. Major findings and conclusions are:

- This well-managed project is on target in achieving most of its objectives; MSH should continue as planned with the implementation of Area Health Systems.
- Project staff should accelerate the design and implementation of the preventive health program in maternal/child health. A mine awareness program also warrants further consideration.
- MSH has done an excellent job of using feedback for program planning; as the project increases in size, every effort should be made to improve feedback monitoring effectiveness.
- Institutional development of the Alliance Health Committee (AHC) has moved slowly. Every effort should be made to hire qualified Afghan staff and to encourage the AHC to strengthen planning, fiscal management and administration.
- It is strongly recommended that O/AID/REP grant a non-competitive extension of the MSH Cooperative Agreement to FY 92.

The assessment team noted the following lessons learned:

- Health care services, even in a war-time, hostile environment, can include a large measure of non-military services for the civilian population.
- Achieving cooperation among donors is difficult because of the diverse interests and backgrounds of organizations working in the health field, given that assistance to the Afghan resistance does not pass through a government Health Ministry.

COSTS

I. Evaluation Costs

1. Evaluation Team		Contract Number OR TDY Person Days	Contract Cost OR TDY Cost (U.S. \$)	Source of Funds
Name	Affiliation			
Vincent Brown Pamela Hunte Charles Stockman Kristen Loken	International Science & Technology Institute AID/W, ANE/HPN	PDC-0000-I-00 6134	88,796	Project # 306-0200
2. Mission/Office Professional Staff Person-Days (Estimate) _____ 10		3. Borrower/Grantee Professional Staff Person-Days (Estimate) _____ 118		

A.I.D. EVALUATION SUMMARY - PART II

SUMMARY

J. Summary of Evaluation Findings, Conclusions and Recommendations (Try not to exceed the three (3) pages provided)
Address the following items:

- Purpose of evaluation and methodology used
- Purpose of activity(ies) evaluated
- Findings and conclusions (relate to questions)
- Principal recommendations
- Lessons learned

Mission or Office:

O/AID/REP
Afghanistan

Date This Summary Prepared:

August 1988

Title And Date Of Full Evaluation Report:

Afghanistan Health Sector Support
Project Assessment (Project No. 306-0203)

Purpose of the Project (Activity)

The purpose of the Health Sector Support Program (HSSP Project 306-0203) is to provide technical assistance: a) to rapidly expand the availability of primary health care and first aid services inside Afghanistan, and b) to strengthen the capability of the Health Committee of the Seven Party Alliance in Pakistan and local leadership inside free Afghanistan, to plan, organize and manage expanded health care activities.

Purpose of the Evaluation & Methodology Used

The purpose of the HSSP evaluation was: to examine needs in the health sector; to assess the effectiveness of the project in light of the original Activity Identification Memorandum (AIM), Activity Approval Memorandum (AAM) and annual work plans; and to revise the AAM to better reflect present and future requirements in the health sector.

Team members met to review the AIM, AAM, work plans, quarterly reports and other relevant project documents in Washington D.C. On arrival in Islamabad, the team was briefed by the Project Officer and Acting A.I.D. Representative. From June 4 - July 9, 1988 the team interviewed project staff and beneficiaries, made site visits in Pakistan and interviewed Private Volunteer Organization (PVO) representatives, members of the Alliance Health Committee (AHC) and the Government of Pakistan liaison officer. A detailed account of the assessment methodology, persons consulted, and a bibliography are found in the Assessment Report.

Findings and Conclusions

The assessment team found the HSSP to be very well managed by a highly experienced MSH team. In general, the HSSP is on schedule in achieving most of its targets. The project has substantially expanded health services inside Afghanistan, addressing a significant portion of the major disease and emergency care needs. In addition, the MSH team's working relations with the Alliance Health Committee (AHC), the medical sub-committee of the AHC, training center staff, and area commanders have been excellent.

One of the most significant project achievements has been the general acceptance of the Basic Health Worker (BHW) and the Area Health System Model by Afghan counterparts. During the first eight months of the project the Training Center was established, the BHW curriculum was developed, and 820 BHW were trained. The Training Center has developed institutionally and will be an asset for any future Ministry of Health.

In Afghanistan, where much of the health infrastructure has been destroyed and personnel have been displaced or killed, there are serious shortages and gaps at all levels of health care. MSH plans to expand its health services to include

maternal/child health care and health/nutrition education to facilitate Afghan resettlement.

To date, BHWs have been recruited and assigned on an equal basis by tanzeem (political parties). More recently, criteria for geographical coverage within each tanzeem have been employed. Teams of Afghan monitors hired by the project have reported about their trips through seven provinces in which 158 BHWs and 11 project-supported clinics are located. In areas surveyed, 51% of BHWs and 90% of clinics surveyed are functioning. A system for monitoring supply movement is in place and functioning.

The AHC's capacity to take on broader management/administration responsibilities has not moved forward as rapidly as training. The absence of the usual government-to-government framework has had many implications for project financing and administrative arrangements. MSH has attempted to strengthen the financial and administrative capability of the AHC, but there are real limits on how much the AHC can currently manage. Presently, only two people on the AHC staff are charged with financial management and administration, and they have limited training and experience.

A significant need to coordinate with other organizations working in the health sector remains. Key tasks include: standardization of salaries for health staff financed by various contractors and PVOs (most of whom are not funded by the USG) and the development of common terminology and definitions for health workers and facilities. During the last year, PVO willingness to cooperate and share information in the forum of the Coordination of Medical Committees (CMC) increased. MSH will continue to work closely with CMC on these issues in the future. When the refugees start back in large numbers (probably in the spring of 1989), organizations operating in Pakistan may begin cross-border assistance. During this transition, there will be a continuing need for coordination to avoid duplication of services, assure complementary programs, and standardize common medical protocols.

Given the complexities of the rapidly evolving situation inside Afghanistan, and the operational role of the MSH team, it will be very difficult to field another team after FY 89 without loss of momentum. A break in continuity leading to rupture in the provision of equipment, pharmaceuticals and salaries of Basic Health Workers (BHWs) would disrupt vital health services and create an enormous credibility problem with the target population. In addition, given the present pace of project activity, additional project funding will be necessary during FY 89.

Principal Recommendations

MSH should continue as planned with the implementation of Area Health Systems.

Project staff should move as rapidly as possible with the design and implementation of maternal/child health services (including CDD and immunization) and health/nutrition education.

The project should give priority to the distribution of personnel and facilities based upon population and needs criteria.

Personnel should be hired to complete the analysis (in conjunction with the AHC) of the Management Information System, to assure directive changes in training, supply, logistics and other support activities takes place.

de

Monitoring of project components should continue. Efforts to exchange monitoring results with cross-border groups should be actively pursued.

MSH should examine the use of incentives to encourage the AHC to strengthen its planning, fiscal management and administrative capacities. Every effort should be made to hire qualified Afghan staff in administrative/management positions.

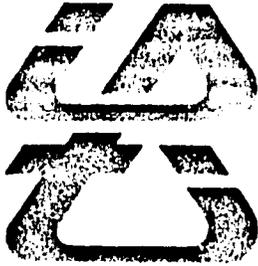
MSH should make every effort to coordinate with the U.N. organizations and CMC as the complex process of Afghan resettlement evolves.

The Office of the A.I.D. Representative should grant a non-competitive extension of the MSH cooperative agreement to FY 92; and provide additional funding to assure no delays in project implementation occur.

Lessons Learned

One of the most important lessons learned from the project is that health care services can reach a large civilian population, regardless of the existence of war-time conditions. Even without an in-country presence, MSH was able to deliver equipment, medicines, and other supplies by working with the AHC, Alliance parties, field commanders and the Government of Pakistan. The project has further demonstrated that institution-building could begin early in project life, even with the dangers and uncertainties of the war situation. Finally, the project has demonstrated the importance of close cooperation between donors; yet, owing to diverse interests and backgrounds of the varied organizations, cooperation is not easy to achieve.

XD-AAZ-001-A



International Science and Technology Institute, Inc.

**AFGHANISTAN HEALTH SECTOR SUPPORT
PROJECT ASSESSMENT**

(Project No. 306-0203)

Courtesy of the
AFGHANISTAN Ministry of
Health and Family Welfare

T. H. Egan, Ph. D.

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XD-AAZ-661-A

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**AFGHANISTAN HEALTH SECTOR SUPPORT
PROJECT ASSESSMENT**

(Project No. 306-0203)

Prepared for:

**The Office of the AID Representative, Afghanistan
U.S. Agency for International Development
(Contract No. PDC-0000-I-00-6134-00)
Delivery Order No. 28**

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August 1988

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LIST OF ACRONYMS AND ABBREVIATIONS

AAM	Activity Approval Memorandum
ACBAR	Agency Coordinating Body for Afghan Relief
AHC	Alliance Health Committee
AID/REP	Office of the A.I.D. Representative
AID/W	Agency for International Development/ Washington, D.C.
AIM	Activity Identification Memorandum
AMEG	American Manufacturers' Export Group
AMI	Aide Medicale International
ANE	Asia Near East Bureau of the Agency for International Development
AHO	Area Health Officer
ALO	Area Logistics Officer
AVICEN	Afghanistan Vaccination and Immunization Center
BCG	Live Anti-Tuberculosis Vaccine
CBHA	Cross-Border Humanitarian Assistance
CEP	Commodity Export Program
CMC	Coordination of Medical Committees
DOD	U.S. Department of Defense
DPT	Diphtheria, Pertussis and Tetanus Vaccine
EPI	Expanded Program of Immunization
EX-PAT	Expatriate
ECC	European Community Commission
FA	First Aid
FM	Freedom Medicine
GAC	German Afghanistan Committee
GOP	Government of Pakistan
HE	Health Education
ICRC	International Committee of the Red Cross
IMC	International Medical Corps
IRC	International Rescue Committee
IUAM	Islamic Unity of Afghan Mujahideen (Alliance)
LAB	Laboratory
MCH	Maternal and Child Health
MCI	Mercy Corps International
MDM	Medecins du Monde
MRCA	Medical Refresher Course for Afghans
MSF	Medecins Sans Frontieres
MSH	Management Sciences for Health
MTA	Medical Training for Afghans
N/A	Not Applicable
NCA	Norwegian Committee for Afghanistan
NGO	Non-Governmental Organization
NWFP	North West Frontier Province
OPD	Outpatient Department (Clinic)
PAK	Pakistan
PDPA	Peoples' Democratic Party of Afghanistan
PVO	Private Voluntary Organization
RA	Republic of Afghanistan

RRD	Resettlement, Reconstruction, and Development
SCA	Swedish Committee for Afghanistan
TRG	Training
USAF	U.S. Air Force
USAID	U.S. Agency for International Development
USSR	Union of Soviet Socialist Republics

GLOSSARY

<u>Atar</u>	Herbalist; Seller of Herbs
Cold Chain	Continuous refrigeration of vaccine from development (manufacture) to delivery (innoculation)
Commander	Military and civil leader
<u>Dais</u>	Birth attendants
Green Books	Medical patient record books kept by health care workers in facilities within Afghanistan
<u>Hakin</u>	Practitioner of the Unani (Greco-Roman medical traditions)
<u>Jirga</u>	Tribal Council
Log Books	Patient record books kept by health care workers at Afghanistan facilities
<u>Mujahideen</u>	Afghan resistance, freedom-fighters (Singular <u>mujahid</u>)
<u>Mullah</u>	Religious Leader
<u>Rupee</u>	Pakistan's unit of currency--US \$1.00 equals approximately Rupees (Rs) 17.5
<u>Shurrah</u>	Tribal Committee
<u>Tanzeem</u>	Afghan political party
Yellow Books	Surgical patient record books kept by health care workers in facilities within Afghanistan

EXECUTIVE SUMMARY

Introduction

The purpose of the assessment team for the Afghanistan Health Sector Support Project (306-0203) was to assess the effectiveness of the project in light of the original Activity Identification Memorandum (AIM), Activity Approval Memorandum (AAM) and annual work plans.

Members of the Health Sector Support Assessment team spent from June 4 to July 9, 1988 in Islamabad and Peshawar assessing the implementation of the project in light of the project objectives and tasks assigned the Management Sciences for Health (MSH) team in the Cooperative Agreement. The team's main base of operations was Peshawar. Extensive discussions were held with members of the MSH project staff. The assessment team had an opportunity to visit the training camps and to meet with the Chairmen and committees of the participating tanzeems of the Alliance Health Committee (AHC), individual members of the AHC Medical Sub-committee, the Director of the AHC Training Center, representatives of the PVOs working in the health field, and the Government of Pakistan liaison officer based in Peshawar.

Setting in Afghanistan

Operating AID's Cross-Border Humanitarian Assistance (CBHA) program for Afghanistan presents unique constraints and challenges not found in most other AID programs in developing countries. Owing to the GOP's concern over the risk of conflict with the Soviet Union if it openly participated in the CBHA, a mantle of strict security was placed over the CBHA program and project operations. Also on security grounds, travel of U.S. citizens and residents was restricted in the border areas of Pakistan as well as prohibited inside Afghanistan.

The signing by Pakistan, Afghanistan, the USSR and the United States of peace accords and the beginning of the withdrawal of Soviet troops from Afghanistan is a welcomed development which will alter the framework in which the Health Sector Support Project can be implemented in the near future. The specific programs and activities of the Health Sector Support Project will need to be managed with substantial flexibility to be able to contend with the new set of circumstances and uncertainties.

While there are no firm population figures, estimates done in the summer of 1987 put the population inside Afghanistan at about 12.6 million including 3 million internally displaced. The size of the refugee population (approximately 3 million in Pakistan and 2 million in Iran) means that withdrawal will trigger one of the largest human migrations since World War II.

The need for basic health care will be tremendous as the refugee population returns and will have a heavy impact on the rural settled population that stayed inside, especially concentrated in the six to eight provinces along the borders with Pakistan and Iran. In over eight years of war practically all previously existing primary health care facilities have been destroyed. Lack of shelter, insufficient food, lack of sanitation and water will make the need for providing minimal primary health care facilities even more critical.

Project Description

The Health Sector Support Project (306-0203) was authorized on August 8, 1986. The Project Assistance Completion Date is now September 30, 1989. Some \$15 million is now obligated within an authorization of \$16.6 million, which includes \$9.9 million for direct program support and \$5.1 million for technical assistance and logistic support costs.

The structure of the project was designed to provide technical assistance: a) to rapidly expand the availability of primary health care and first aid services inside Afghanistan and b) to assist in the development of the capability of the Alliance Health Committee (AHC) to plan and manage expanded health care services and participate in the eventual reconstruction of Afghanistan.

AHC has been organized and staffed with a dedicated full-time Afghan staff/secretariat. An effective Training Center is functioning, and a preventive Health Services Unit has been established and is working on a pilot vaccination program. On the planning side there is a very active AHC Medical Sub-committee. The Training Center has done very well institutionally and would be an asset for any future Ministry of Health or National Institute of Public Health. The AHC capacity to take on broader management/administration responsibilities has not moved forward as rapidly as training.

The contractor (MSH) has provided a very competent team: Team Leader, Management Advisor (Deputy Team Leader), Training Advisor, Medical and Field Operations Advisor, Preventive Medicine and Technical Procurement Advisor, as well as a Fiscal Officer. Substantial local staff hired by the contractor assist with the operational tasks of preparation and supply of medicine kits, transportation, payment of salary to BHWs, and other medical personnel, etc.

Accomplishments to date under the project are impressive with most of the second year work plan goals achieved (see Table 1 which follows: "Planned and Achieved Outputs of the Health Sector Support Project.") Given the difficulties of operating a cross-border health program in Afghanistan (i.e., establishing curriculum and training facilities), the team judges the achievements to be outstanding even though in some cases they are short of second year work plan goals.

TABLE 1: PLANNED AND ACHIEVED OUTPUTS OF HEALTH SECTOR SUPPORT PROJECT

<u>ACTIVITY</u>	<u>PLANNED FY88</u>	<u>ACHIEVED TO DATE</u>	<u>COMMENT</u>
AHC-supported clinics	54	54	30 more this year. 1 Provincial and 7 District will be delivered this year.
AHC-supported hospitals	18	0	
BHWs assigned to field	960	809	
Nurses assigned	*	40	
Doctors assigned	*	29	
Paramedics assigned	*	120	
Advanced Medical Students assigned	*	17	
Teams of Monitors deployed	4	21	
Comprehensive MIS	implemented	initiated	
Updating for 7 areas:			
population info	yes	yes	
personnel info	yes	yes	
drug utilization	yes	yes	
transport cost	yes	yes	
Area Health Plans adopted	7	2	1 more this year
Area Health Officers appointed	4	2	1 more this year
Area Logistics Officers appointed	4	1	1 more this year
AHC Medical Sub-Committee functioning	1	1	
Casualty Evacuation Systems	1	0	Objective dropped from Yr 2 plan
BHWs supplied	960	809	
BHWs resupplied	813	276	
Clinics supplied	54	54	30 more this year 1 provincial and 7 district hospitals this year
Hospitals supplied	18	0	
Clinics resupplied	60	10	
Hospitals resupplied	18	0	
Smallscale immunization campaigns initiated	*	yes	
Immunization program	1	1	

*Original objective not quantified

SOURCE: MSH, Peshawar, July 1988 and Work Plans for Year 2.

Management of the Health Sector Support Project is atypical in that the contractor working with AHC is not only responsible for technical advice, but also for implementation (training, curriculum development, payment of salaries, procurement, logistics, finance/accounting, administration, monitoring, and evaluation). In most developing countries where a host government is established, these functions, systems, and operating procedures are already in place and carried out by local institutions.

Given the urgent curative and preventive health needs in Afghanistan's war-torn society, the MSH team's work with the AHC and Regional Commanders has required that priority be given to solving organizational and operational problems so that provision of health care services to the mujahideen and the civilian population could be expedited, and coordinated. Cooperation with other contractors, grantees, PVOs and aid agency representatives has also been emphasized.

While institutional development has always been a primary objective, it is rapidly becoming more important as the Soviets leave Afghanistan, the mujahideen take over, and regional/local governments emerge.

The assessment team is very pleased with the progress of the Health Sector Support Project to date. The contractor has done an excellent management job under difficult conditions, finding imaginative solutions to new and challenging problems in a complex setting which is now in transition.

Looking to the future, the assessment team is concerned that the project not lose the momentum already built up, or more importantly, have a rupture or hiatus, and considers it wise to continue the present team in an extension from FY 88-FY 89.

Given the complexities of the local scene and the operational role of the MSH team, and looking beyond FY 89, it should be noted that it will be very difficult to field a new team without loss of momentum, given the time needed to establish substitute operating systems, gain experience, establish contacts, and follow the rapidly evolving situation inside Afghanistan. Therefore, the MSH team should be continued through FY 92.

Based on its favorable assessment of the project to date, the team agrees fully with the \$20.7 million program level (Option A in the second year work plan, and included in the AID/Representative's request for FY 89 funds).

Principle Recommendations by Subject

Financial Recommendations

1. Current instructions to MSH for "aggressive implementation" should be reflected in the AAM Amendment financial levels with follow-up action started as soon as possible.
2. For program management purposes, current and future funding availability should be made as concrete as possible, even in the face of the difficulties in doing so.
3. AID should start immediately to assure (insofar as possible) that there will be no hiatus between the present completion date (PACD) of September 1989 for the Health Sector Support Project which is growing rapidly in terms of output, and the major follow on activities which will be addressed in the revised AAM.
4. AID management should take the necessary steps to make available sufficient FY 89 funds, of the \$12 million, (already requested from AID/Washington) early in the first quarter of FY 89, in order to avoid ruptures of stock, elimination of medical services, creation of distrust, etc. If this is not possible, additional FY 88 funds should be made available to diminish this risk.

Health Services Recommendations

1. Continue as planned with the implementation of Area Health Systems, including the assignment and support of BHWs, clinics, and rural hospitals where local leadership has shown strong organizational effectiveness.
2. The project should develop a strategy for expanding MCH service availability and utilization, including pregnancy and childbirth.
3. The project should proceed rapidly to incorporate the new tanzeems (especially Sayyaf's political party) into field operations. It is essential that the project continue to distribute personnel and facilities based upon population and needs criteria.

Procurement/Logistics Recommendations

1. AMEG should be relieved of the requirement to procure for the Health Sector Support Project as soon as alternative arrangements can be made and put into effect, as recommended by the Commodity Export Program (CEP) Assessment team.
2. The contractor (MSH) for the Health Sector Support Project should handle the health procurement function to maintain full management control and bring health expertise to bear most effectively.
3. A procurement officer, plus the necessary local staff should be recruited and hired by MSH to assure that the transfer of purchasing responsibility takes place in a timely and orderly fashion.

Training and Education Recommendations

1. Since health education represents one of the mechanisms for reaching the female population and improving their health status, development of a health education program should receive emphasis during this last quarter of 1988.
2. The AHC Training Center should establish a Health Education Unit to design and implement this program. Also, a health education component should be added to the refresher training courses.
3. Training courses for various mid-level health workers, e.g., medical technicians, should be postponed until analyses of future need and anticipated availability of trained personnel for recruitment can be completed and a shortage established.
4. Plans to establish regional training centers, to move forward with the mobile training units, and to field training assessment teams should move forward without delay.

Fiscal Management and Administration; Program Planning Recommendations

1. Additional incentives (such as training, workshops and planning technical assistance) should be considered in order to encourage AHC action to strengthen planning, fiscal management and administration.

2. The current need to develop plans for future activities should be used to encourage the AHC Health Sub-committee to continue to develop its ideas for the future including cost estimates.
3. Efforts should be made to lengthen the audit trail, as the situation inside Afghanistan makes it possible.

Monitoring, Evaluation and Accountability Measures

1. Every effort should be made to keep the monitoring feedback's effectiveness, and to make necessary program and activity modifications, such as stopping payment and delivery of supplies to non-functioning BHWs, bringing problems discovered to AHC's attention, and devising new or modified solutions to problems.
2. The current effort to exchange monitoring results among the contractor/grantees carrying out cross border activities should be pursued actively.

Coordination With Other Contractors, Grantees (PVOs) Recommendations

1. MSH as a recent full member of CMC should participate fully in its activities with a view to helping it become more effective.
2. MSH should consider encouraging the CMC to play a more active role in helping coordinate specific activities of joint interest.

1.0 INTRODUCTION

1.1 Purpose

The purpose of the assessment team for the Afghanistan Health Sector Support Project (306-0203) was to: "assess the effectiveness of the project in light of the original Activity Identification Memorandum (AIM), Activity Approval Memorandum (AAM) and annual workplans...." (For more detail see Appendix I - Scope of Work.)¹

1.2 Methodology

Members of the Health Sector Support Assessment team spent from June 4 to July 9, 1988, in Islamabad and Peshawar assessing the implementation of the project in light of the tasks assigned the Management Sciences for Health (MSH) team in the Cooperative Agreement referenced in Section 2.0 below.

The composition of the assessment team was as follows:

Vincent Brown	Team Leader/Development Economist
Pamela Hunte, Ph.D.	Social Scientist/Ethnographer
Kristin Loken	Health Specialist
Charles Stockman	Senior Finance Specialist

In carrying out their mandate, the team members began with a Team Preparatory Meeting (TPM) in Washington for two days in early May, and reviewed the AIM, AAM, work plans, quarterly reports, and other relevant documents. On arrival in Islamabad, team members were briefed by the Project Officer, Dr. Carole Scherrer-Palma, and Acting AID Representative, Jack Miller.

The team's main base of operations was Peshawar. Extensive discussions were held with Dr. William Oldham and the members of his MSH staff regarding the Health Support Project. The team had an opportunity to visit the training camps and to meet with the Chairman of the AHC, individual members of the AHC Medical Sub-Committee, the Director of the AHC Training Center, representatives of the PVOs working in the health field, and the Government of Pakistan liaison officer based in Peshawar.

A more detailed account of the methodology utilized is contained in Appendix II. A listing of persons consulted and a bibliography are found in Appendix IV and Appendix III, respectively.

¹ Other tasks such as examining the needs in the health sector and their related macro-economic and fiscal impact will be reflected in the revision of the Activity Approval Memorandum (AAM) "to better reflect the present and future requirements in the health sector."

1.3 Setting in Afghanistan

1.3.1 The Context for AID's Cross-Border Humanitarian Program

1.3.1.1 Constraints

U.S. Government (USG) policy now prohibits U.S. citizens or residents who are employees of AID and U.S.-funded contractors or grantees from venturing into Afghanistan so long as there is a significant Soviet presence and a security threat. This policy has obvious implications for the AID/Rep's ability to monitor the end-use or impact of resources delivered to Afghanistan. U.S. PVOs are already lobbying for the removal of this prohibition.

As one looks to the future under changed conditions, current policy will need to be re-examined to test its validity or to recommend a change. With the potential for a significant increase in activity under the Health Sector Support Project, it will become imperative for the AID/Rep's Office to acquire access to project areas (where USG commodities and services are delivered) in Afghanistan. Increased access will permit the monitoring of the end-use of AID health activities and commodities, and will enable the gathering of information on impact of our assistance (particularly with respect to the provision of primary health care to the Afghan people); this information can then be utilized to increase the effectiveness of assistance under the project.

The AID/Rep will continue to assess the security situation in Afghanistan and, in consultation with Embassy officials, will decide whether a change in policy concerning the travel of AID officials, AID-financed U.S. contractors, and PVO representatives should be recommended. Through periodic reporting, the AID/Representative will keep Washington policymakers informed of changes in security conditions.

1.3.1.2 Present Trends

The signing by Pakistan and Afghanistan of peace accords concerning the withdrawal of Soviet troops from Afghanistan is a welcome development which alters the framework in which the Health Sector Support Project can be implemented in the coming months. Some decisions and policies made under previous assumptions may require review and update.

The specific programs and activities of the Health Sector Support Project will need to be managed with substantial flexibility to be able to contend with the new set of uncertainties. These include: (a) the rate at which there is a reduction in fighting; (b) the evolution of effective governing

entities and the continuing movement toward a provisional government; (c) the time needed for the existing Afghan regime to be superseded by a new government; (d) the level and conditions of economic assistance other donors (possibly including the USSR) may provide in the future; (e) the rate at which the Afghan refugees and displaced persons return to their homes; and, (f) the post-war conditions of the economy and environment of Afghanistan. The AID/Rep recognizes these uncertainties, and the assessment team concurs fully in the need for flexible implementation mechanisms and constant policy review for the amended project.

1.3.2 Political, Social and Economic Factors

With the Soviet withdrawal from Afghanistan underway, a difficult, complicated process of resettlement, reconstruction and development (RRD) has begun and the challenges are enormous.² While there are no firm population figures, estimates done in the summer of 1987 put the population inside Afghanistan at about 12.6 million including 3 million internally displaced persons.³ The size of the refugee population (approximately 3 million in Pakistan and 2 million in Iran) means that withdrawal will trigger one of the largest human migrations since World War II. The need for basic health care will be tremendous as the refugee population returns, which will have a heavy impact on the rural settled population that stayed inside. In over eight years of war practically all previously existing rural primary health care facilities have been neglected or destroyed. Lack of shelter, insufficient food, lack of sanitation and water will make the need for providing minimal primary health care facilities even more critical.

In sum, post-war Afghanistan will need massive assistance-- financial, technical, and managerial--to survive and eventually to permit the basic functions of government to develop. Whatever structures evolve, they must be created of Afghan will and actions. Afghan administrative divisions could be based on current regional commanders and jirgas (tribal councils), which already recognize major ethnolinguistic considerations, lines of communication, former and current commercial trading patterns, and

² The text of this brief background section (1.3.2) is based on the Afghanistan Resettlement, Reconstruction and Development Strategy Statement; Reconstruction and Development Strategy (unclassified); the Agricultural Survey of Afghanistan; and other background documents made available to the team as well as its talks with knowledgeable Afghans and expatriates intimately connected with the RRD effort.

³ Table 3, Case E, Population Projections, Food Prospects in Afghanistan - An Assessment, by Raymond W. Hooker, Ph.D., for the O/AID/REP under a contract with VITA, Peshawar, June 1987.

so forth. A regionally differentiated approach which recognizes current and probable future political realities may be required. The basic task of the international donor community will be to administratively tap the new governing and social structures as they evolve.

For example, the Seven Party Alliance announced the formation of a provisional transition government on June 19, 1988. While little is known about the future effectiveness and acceptability of this temporary structure inside Afghanistan, it represents a potential step toward establishing a national administrative structure which could eventually serve as the basis for a stable Islamic nation.

From an economic standpoint the situation is grim. The most comprehensive survey ever undertaken of Afghanistan's agriculture (20,000 interviews in 1,300 communities with 11,000 retained) shows that largely because of the systematic destruction of animals and agriculture, food production has dropped to 45% of its 1978 pre-invasion levels.⁴ The survey shows that 30% of the agricultural land has been left uncultivated. The number of cattle has decreased by 55%, the number of sheep and goats by 66% and the number of horses by almost 45%. The survey covered 29 provinces in the 80% of the country controlled by the mujahideen (freedom fighters). It seems clear that time and concerted effort will be required to restore production to 1979 levels, even with generous help from the international donor community and strong efforts by the Afghans themselves.

Industry and commerce which was very modest in the past has been severely disrupted by the Soviet occupation. Open and expanded trade channels may be initiated as the country is freed from Soviet occupation, civil strife abates, and these areas come under the control of de facto resistance authorities, but the economy will take some considerable time to recover from eight years of almost exclusive ties to the Soviet Union and the Bloc countries.

No less important is the restoration of the educational system which has been severely damaged at all levels. As a result of the war, the vast majority of young people have received no education at all. The lack of trained health professionals at all levels will also require a substantial educational effort.

Within this context of competing priorities during the resettlement, reconstruction and development phases, basic health care will be front and center with the repatriation of the refugees. Facilities will have to be built and training activities

⁴ Dr. Azam Gul, Director of Survey, First Report on The Agricultural Survey of Afghanistan, implemented by the Swedish Committee for Afghanistan, Peshawar, May 1988.

will have to be expanded geometrically. Provision of minimal health care to the population with preventive and curative programs may have strong political overtones as the fighting stops and the people look to their regional leaders for minimal health services and protection against epidemics and endemic diseases they now know can be prevented. Until the mines are cleared, fundamental first aid and trauma treatment will also continue to be a priority.

The team is convinced that the Health Sector Support Project, which is assessed in the following sections, has a major role to play in the RRD process.

1.3.3 Epidemiology of Disease and Population Demography

No valid, reliable data on health conditions in Afghanistan exist. The information that follows is estimated from the accounts of visitors, the analysis of green books (field reports) of health personnel working in Afghanistan, and extrapolation from pre-war data. This is the best information that is available now and, in our opinion, is as accurate a representation of conditions in Afghanistan as possible under the circumstances. However, the team makes no claim to its scientific accuracy and suggests the reader interpret this information as provisional.

1.3.3.1 Health and Nutritional Status

Prior to the war, Afghanistan was one of the least developed countries in the world with high mortality and fertility rates. Current estimates of these indicators place the infant mortality as high as 189 per 1,000 births (up from 157 pre-1977) and child mortality at 329 per 1,000. The main killers of young Afghan children are preventable infectious diseases, diarrhea, and acute respiratory disease combined with malnutrition. Recent PVO reports indicate that 32 to 40 percent of the children die before reaching the age of five. This means that during the last seven years as many as two million children have died mostly of preventable causes inside Afghanistan.⁵ Maternal mortality has been observed to be relatively high as well probably resulting from post partum hemorrhage, retained placenta, problems associated with multiple deliveries, and tetanus. Although estimates vary, it is believed that there have been one million deaths resulting from the war.

Fertility in the refugee camps at 13.6 births per woman may be the highest in the world. Typically, seven of these children are born alive and four to five survive beyond the age of five. Because refugee populations have been known to exhibit extremely high

⁵ UNICEF, Immunization of Afghan Children, C/ICEF/1986/P/L.27, April 1988.

fertility levels, actual fertility rates inside Afghanistan are assumed to be somewhat lower, though still high because conditions which correlate with high fertility rates (low levels of female education, rural residence, subsistence-level standard of living, early age of marriage, and preference for large families) continue to exist within the Afghan society.⁶

Since 1979, the general health situation in Afghanistan has worsened due to deterioration in environmental conditions such as internal displacement and migration of whole villages causing overcrowding and poor hygienic conditions, which have increased the transmission of communicable diseases. The war has disrupted the delivery of health services outside Kabul City, destroyed health infrastructure, and displaced much of the personnel. Water systems have been destroyed and polluted. Transportation in some areas has been drastically reduced, sometimes limited to pack animals and travel by foot, which makes the movement of injured and sick difficult.⁷ Various types of anti-personnel mines were deployed in rural fields and forest areas and along roads and canals. These mines will remain after the Soviet withdrawal. These conditions are made worse by extreme heat in the southwest desert and cold weather conditions in mountain areas where temperatures average below zero degrees centigrade (32 degrees F.) for five to six months every year.

Reliable incidence and prevalence data are lacking. However, we have the following information (presented on the following two pages) reporting major health problems from three local sources based on green book (field report) analysis.

⁶ Krijgh, Ellen, Health Status of Afghan Women and Children: An Assessment of Trends in Ten Refugee Camps, International Rescue Committee, Pakistan, 1987.

⁷ Hunte, Pamela A., et al., Evaluation of AID/Rep-Assisted Private Voluntary Organizations (PVOs) Providing Health-Related Assistance to War-Affected Afghans, USAID, 1987.

MOST COMMONLY REPORTED HEALTH PROBLEMS

International Medical Corps (1986-87).⁸

	% of Total Cases (N=21,893)
Bronchitis	8.8
Hyperacidity/Gastritis	6.4
Diarrhea	5.9
Parasitosis	5.8
Cold	5.1
Trauma*	3.5
Other	<u>64.5</u>
Total	100.0

Alliance Health Committee/MSH (1987-88).⁹

	% of Total Cases (N=Unknown)
Bronchitis/Pneumonia/Asthma	13.8
Common Cold/Cough	8.3
Parasites	8.0
Arthralgia	7.9
Gastritis/Ulcer	6.6
Diarrhea	6.5
Trauma*	0.1
Other	<u>48.8</u>
Total	100.0

* The figures for trauma are probably underreported. Although there are certainly war-related medical problems, they are not as might otherwise be assumed, among the highest percentages reported. This is in part explained by the idea that, until recently, many of the injured mujahid died before reaching health facilities or health workers and, therefore, were not reported. Although there are exceptions, trauma seems to average four to five percent of total cases in current green book data. On the other hand, the entire population suffers on a regular basis from the above listed health problems. Therefore, it is reasonable that these would be more prevalent and more commonly reported.

⁸ Halbert, R.J., et al., Pattern of Disease in Rural Afghanistan, CMC, 1988.

⁹ Ickx, Paul, Pathology in Afghanistan in Various Health Stations, MSH, 1988.

MOST COMMONLY REPORTED HEALTH PROBLEMS (Cont'd.)

Medecins Sans Frontiere (1982-85).¹⁰

	% of Total Cases (N=49,147)
Worms	14.0
Rheumatism/Arthralgia	12.8
Malaria	6.0
Gastritis/Ulcer	5.9
Acute Bacterial Infection	5.3
Conjunctivitis	5.0
Trauma*	1.1
Other	<u>49.9</u>
Total	100.0

* See previous page for notation re trauma figures.

¹⁰ McGill, John, Statistics on Diagnoses made by Expatriates Working at Medecin Sans Frontiere Hospitals in Afghanistan, CMC, 1987.

The AHC/MSH and IMC data were collected during the winter months. Therefore, malaria does not show up in the above tables, although it is endemic in all areas under 2,000 meters elevation and is even imported into some areas of greater altitude due to the increased use of higher mountain trails for movement and transport. Falciparum and vivax are reported, as has been cerebral malaria. Tuberculosis has become a significant problem in all regions among all ethnic groups. Other diseases which are reported as being common are pertussis (whooping cough) and measles due to the absence of immunization. Leprosy, polio, anthrax, and cholera have also been reported.¹¹

Nutritional status is reported now to have not deteriorated greatly from the pre-war period when childhood malnutrition was a serious health problem. There are reports of some undernutrition due to the higher cost and, in some locations, non-availability of nutritious foods such as fruits, meat/poultry, and vegetables. Of concern are the recent reports that many women are experiencing a loss of breastmilk three or four months after giving birth. This is attributed to the poor diet consumed by women, mainly bread and green tea.¹²

Some local health and nutrition practices contribute to poor health status. These result generally from lack of information. Fluids and sometimes food are withheld from infants with diarrhea. Mothers tend to introduce supplemental foods to nursing infants later and then introduce less nutritious foods such as tea or rice. Likewise, foods used during weaning are of less nutritious quality. Finally, there is the Afghan preference for injections over other forms of medical treatments and even preventive services. It is said that many Afghan homes keep a syringe which is used to inject family members without sterilization.

1.3.3.2 Demographic Profile

According to one set of projections,¹³ "tremendous changes are occurring in the geographic distribution of the population remaining in Afghanistan." This is estimated to be 12.6 million, not including the 5 million refugees outside the country. This report continues, "there has been movement away from the more accessible, flatter, more agriculturally productive areas into the hilly, mountainous areas and especially into the cities....The city of Kandahar has doubled while surrounding villages

¹¹ Ickx, Paul, Some Data on Morbidity and Health Facilities Inside Afghanistan, MSH, 1988.

¹² Unknown, "Notes on Monitoring Visit Inside Afghanistan," MSF, 1987.

¹³ Hooker, Raymond W., Food Prospects in Afghanistan, An Assessment, USAID, 1987, pp. 24-26.

have been mostly destroyed....In Farah province, 40% of the population has moved to Iran but the population of Farah City has more than tripled....The growth of Kabul City has been spectacular from a pre-war population of 600,000-700,000 to a current population estimated to be between 2.5 and 4.5 million." This same source estimates the following population distribution:

<u>In Millions</u>		
Urban Total		4.0 (32%)
Kabul Province		2.6
Kabul City	2.5	
Other	0.1	
Other Provinces		1.4
Nomads		1.0 (8%)
Settled Rural		<u>7.6</u> (60%)
Total Population		12.6

1.3.3.3 Health Needs and Priorities

While recognizing the limitations of this information, there does appear to be substantial need for health assistance to the people of Afghanistan. The war has created large gaps in health care coverage in a country which had a serious pre-war deficiency.

Based on the above, the major kinds of health services needed are:

- o Maternal and child health including immunization, oral rehydration, prenatal care, growth monitoring, and child spacing/family planning;
- o Simple curative services for diarrheal disease, conjunctivitis, anemia, acute respiratory illnesses, worms, and parasites;
- o First aid and emergency care; and
- o Health and nutrition education.

For socio-cultural and political reasons, the project contains no family planning. Due to the difficulties in recruiting females and the general reticence against women being seen by male health personnel for obstetrical and gynecological reasons, few females are receiving health care through this or any other project anywhere in Afghanistan. The project has initiated an immunization program and does provide simple curative services, first aid, and emergency care. A health education program is planned for initiation in the near future. From the information available it also appears that a rural focus for the project is appropriate because these areas are most in need of services.

In a relatively short period of time, the project has contributed significantly to the development of Afghan institutions which plan and manage health care services in Afghanistan. The most impressive of these is the AHC Training Center. Other entities which have been established or strengthened are: AHC Medical Subcommittee, AHC Preventive Health Unit, AHC Clinics Division (field operations), and the first Area Health Administration in the North East. Of these, at a minimum the AHC Training Center will have the capability to participate in the eventual reconstruction of Afghanistan.

2.0 PROJECT PURPOSE AND TASKS

2.1 Purpose Set Out In Activity Authorization and Activity Approval Memorandum (AAM)

The Authorization states that the Activity:

...will provide, inter alia, for a program of health sector support, including health services and commodities, for the free Afghan people remaining in Afghanistan and for technical assistance in connection therewith.

2.1.1 Program Objectives and Activities

The AAM prepared by MSH which was approved by AID/W states that the Program had three objectives...to expand and improve (1) medical and surgical care for war casualties; (2) general health care for civilians as well as mujahideen; and (3) the capability of the Health Committee to plan and manage expanded health activities to better support the war effort and eventual national reconstruction.

To accomplish these objectives, emergency care services in Afghanistan will be expanded by training more first aiders and nurses; urgent care will be improved by setting up Mobile Health Clinics, small Mobile Hospitals in more secure areas; evacuation systems will be improved; and some funds may be made available for expanded beds for women and children in Pakistan. The training strategy is to build on strengths of the PVOs and parties but also to increase the capability of both, so that training can be rapidly expanded. AID will finance the costs of a supply service to provide equipment, drugs, and expendable medical supplies. AID will also finance transportation costs as required.

2.2 Purpose Set Out in Cooperative Agreement With MSH

The following statements are taken from the Cooperative Agreement Schedule/Attachment 1 and describe the MSH obligations under the Cooperative Agreement:

To provide technical and financial humanitarian assistance to expand and strengthen health services inside Afghanistan as rapidly as possible and strengthen the capability of the health committee of the Seven Party Alliance to plan, operate, and monitor expanded health services in Afghanistan.

2.2.1 Major Tasks

Specifically, the Recipient's (MSH) efforts shall include but not be limited, to the following:

- Assisting the Alliance Health Committee (AHC) in the expansion and improvement of medical and surgical care for war casualties, e.g., emergency care services, urgent care services, evacuation services and continuing care services;
- Assisting the Alliance Health Committee (AHC) in the expansion and improvement of general health care for the civilian population and mujahideen, e.g., primary health care and in-patient services, selected immunization services and public education services:
- Improving the capability of the Alliance Health Committee (AHC) in planning and managing expanded health activities, and in the training of first-aiders, nurses and doctors;
- Assisting the Alliance Health Committee (AHC) in developing the type and quantity of supplies required, assisting in distribution, and in the development of systems for supply and resupply;
- Providing close coordination with contractors and grantees who are providing medical supplies and equipment in order that those items are delivered on a timely basis and are available when needed; and
- As appropriate, review and comment on grant requests to the O/AID/REP for Afghan Affairs by PVO's for health-related projects.

2.3 Conclusions

The team has examined the objectives as laid out in the AAM which was based on the AIM done in January 1986, and compared them to those set forth in the Cooperative Grant with MSH. When the Cooperative Grant was prepared in September 1986 the situation had evolved, and more specific reference to support of the Afghanistan Health Committee (AHC) was possible. (The contractor--MSH--is, of course, only bound by the purposes and tasks in the Cooperative Grant Agreement.) In addition, the first and second year work plans worked out jointly by MSH with AHC and AID further focused the project activities within the framework of the general objectives in both documents.

In summary, the team has concluded that while there are some changes in specifics (for example, leaving mid-level training--medics/nurses--to the PVOS, and MSH concentrating on Basic Health Workers) the Cooperative Grant was correctly done as a natural outgrowth of the AAM.

Therefore, the objectives and activities of the Health Sector Support Project are not only consistent in both the AAM and the Cooperative Agreement, but they are also valid for the project for the present and near future.

The decision to make the first and second year work plans major implementation documents, which reflect the realities or dynamics of a rapidly changing situation, has turned out to be sound and is very much in line with the flexibility needed to carry out this project.

3.0 GENERAL PROJECT DESCRIPTION

The Health Sector Support Project (306-0203) was authorized on August 8, 1986. The Project Assistance Completion Date is now September 30, 1989. Fifteen million dollars is now obligated within an authorization of \$16.6 million, which includes \$10.6 million for direct program support and \$5.1 million for technical assistance costs.

The structure of the project was designed to provide technical assistance: a) to rapidly expand the availability of primary health care and first aid services inside Afghanistan, and b) to assist in the development of the capability of the Alliance Health Committee (AHC) to plan and manage expanded health care services and participate in the eventual reconstruction of Afghanistan. By March 1987 the AHC had organized and moved into their offices. Until very recently, three of the seven original AHC tanzeems (political parties) had not joined the project. Khalis' Hezb-i-Islami tanzeem opposed the concept of the Alliance and Hikmatyar's Hezb-i-Islami and Sayyaf's Etehad-i-Islami, decided to wait for the establishment of an office by the Government of Pakistan (GOP) which was to serve as an intermediary between the AHC and the technical assistance team provided by the U.S. firm, Management Sciences for Health (MSH). An additional consideration may have been that these tanzeems believed they would lose other donor assistance had they participated in a project funded by the U.S. government. Today, the fifth tanzeem (Khalis' Hezb-i-Islami) has joined the AHC and the sixth (Sayyaf's) is expected to join soon. (A list of all seven tanzeems is provided in Appendix V.)

This project has a main focus on directly addressing the need for Afghan institution building. The AHC has shown steady development during the second project year. The AHC High Council was formed to give overall oversight and policy direction. The High Council is composed of the Chairmen of the health committees of the participating tanzeems with the presidency rotating among the Chairmen every four months. Working as an advisory body to the High Council for policy and planning is the Medical Sub-Committee, which also plays key roles in personnel selection and certification, technical direction, and internal coordination. Its members include the directors of the Training Center, of curriculum development, of preventive health, and of the hospital of the National Islamic Front. Four operations departments have been formed within the AHC (finance and administration, medical services or clinics, logistics, and training).

Technical assistance has been required in getting the AHC on its way to developing the capacity to plan, operate, monitor, and evaluate the larger, more complex health system envisioned by the project. A technical assistance team was provided by MSH under a Cooperative Agreement with the AID/Rep. Under the terms of this Agreement, MSH has provided a Team Leader, a Management Advisor (who also serves as Deputy Team Leader), a Training Officer, a Medical

and Field Operations Advisor, and a Fiscal Officer. There is also a long-term personal services contractor in charge of immunization and procurement and a Project Coordinator based in the MSH offices in Boston.

During the second year of project implementation, another set of key project actors has been added. These are the local and regional leaders, including military commanders and tribal jirgas and shurrahs. The participation of these leaders is consistent with the AID/Rep strategy to implement programs at the local or regional level during the transitional phase and to maximize program effectiveness by encouraging direction by strong local leadership. The eventual importance of the tribal leaders is recognized by the project although to date activities have only been initiated with some regional or area military commanders. This leadership is important to the successful implementation of the Area Health System model, which has already been adopted in two regions (the North West and North East) with discussions underway in a third region. (See the map on the following page, Figure 1, for delineation of the seven regions in Afghanistan.)

In 1986 the GOP assigned a liaison officer to serve as intermediary between the Resistance and the AID/Rep activities in Peshawar. The arrangement has greatly facilitated project progress. Not only was the liaison officer knowledgeable and an excellent organizer and translator, but his presence clearly demonstrated the importance of close GOP, AHC, and USG coordination. Since many of the project activities and offices are located in Pakistan, the GOP intermediary has proven to be a necessary and extremely helpful partner in the health program.

MAP OF AFGHANISTAN
Showing Zones and Provinces

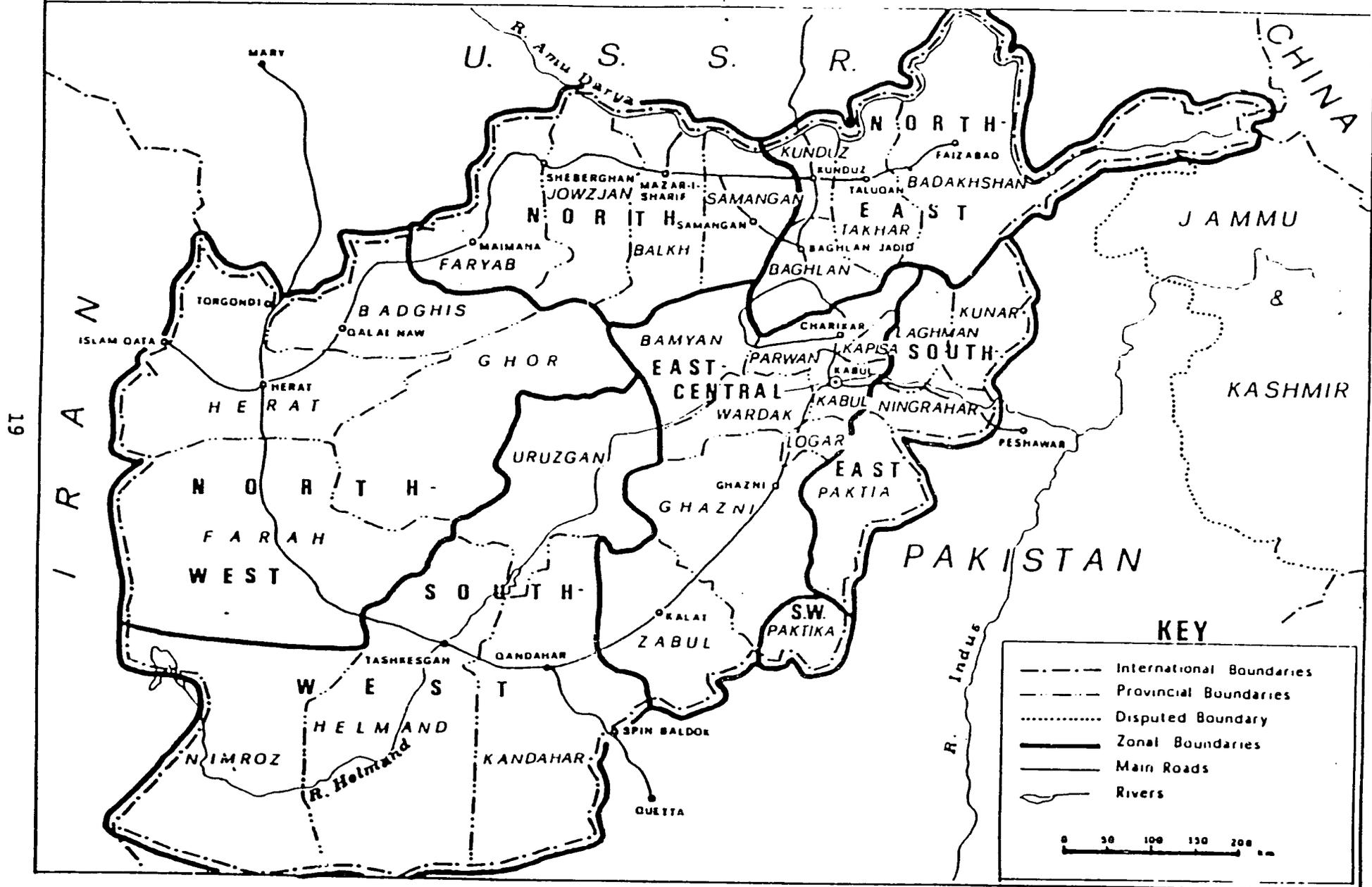


Figure 1

Source: Agricultural Survey of Afghanistan, May 1988.

4.0 ASSESSMENT OF PROJECT PERFORMANCE INCLUDING MAJOR COMPONENTS

4.1 Overview of Project Management

4.1.1 Context (Findings)

Management of the Health Sector Support Project is atypical in that the contractor working with AHC is not only responsible for technical advice, but also for implementation (training, curriculum development, payment of salaries, procurement, logistics, finance/accounting, administration, monitoring, and evaluation). In most developing countries where a host government is established, these functions, systems, and operating procedures are already in place and are carried out by local institutions.

Given the urgent curative and preventive health needs in Afghanistan's war-torn society, the MSH team's work with the AHC and Regional Commanders has required that priority be given to solving organizational and operational problems so that provision of health care services to the mujahideen and the civilian population could be expedited and coordinated. Cooperation with other contractors, grantees, PVOs and aid agency representatives has also been emphasized.

While institutional development has always been an important objective, it is rapidly becoming more important as the Soviets leave Afghanistan, the mujahideen take over, and regional/local governments emerge. Over the coming months and the next several years, in addition to continuing the institutional development work with AHC (or its successor agency), the Health Sector Support Project will need to focus on helping to establish local institutions with operational capacities which can become part of the permanent structure when the transitional phase is completed and a stable Islamic government is established.

The team found the Afghan Health Sector Support Project to be very well managed by a highly experienced MSH team possessing the requisite skills needed to carry out the purpose and tasks set forth in the Cooperative Agreement (see Section 2.0 above). Provision of short-term experts in areas where specialized skills are needed (e.g., certification of qualified suppliers of medicine in Pakistan) has worked well under the project. The MSH team's working relations with the Afghanistan Health Committee, the Medical Sub-committee, the Training Center staff, and training units in the camps as well as with the area commanders and area medical officers have been excellent.

The MSH team has performed remarkably well in moving toward meeting the goals set out in its second year work plan given the uncertainties and difficulties of operating in Afghanistan from Pakistan. In areas where performance has been slow, such as establishing First Aid "Buddy" training in the camps, and

purchasing the medical supplies for the clinics inside Afghanistan, most of the obstacles have been overcome. Specific performance as well as funding requirements are described in this Section 4.0, and in Section 5.0, Financial Considerations, which follows.

The contractor has kept a tight rein on disbursements and accountability with imaginative use of monitoring teams to follow up on the use inside Afghanistan of the equipment, medical supplies, and Basic Health Workers (BHWs) whose salaries are paid under the project. The contractor has also been encouraging the AHC to strengthen its administration and financial management and plans some management training for the AHC.

On the institutional side the AHC Training Center is well run by its Afghan staff. The areas of planning, administration and accounting described below are only beginning to be addressed by the AHC. Considerably more time, effort, training, and establishment of indigenous systems and procedures will be required before the AHC can take over payment of salaries, purchases of services, operation of logistic backstopping, and so forth.

In summary, the AHC has been organized and staffed with dedicated full-time Afghan personnel. An effective Training Center is functioning, and a preventive Health Services Unit has been established and is working on a pilot vaccination program. On the planning side there is a very active AHC Medical Sub-committee. The Training Center would be an asset for any future Ministry of Health or National Institute of Public Health. The AHC capacity to take on broader management/administration responsibilities has not moved forward as rapidly as training, but this activity remains a high priority.

Work with other grantees (PVOs), the Swedish Committee for Afghanistan (SCA), and other members of the non-governmental organization Coordination of Medical Committees (CMC), has moved slowly with ups and downs, but some progress has been made on specific topics (see Section 4.7 below). The MSH team has worked quietly with members of the CMC since the project started, and has recently become a full member.

4.1.2 Conclusions/Lessons Learned

The Health Sector Project has moved forward very well to date. The MSH team has done an excellent management job under difficult conditions finding imaginative solutions to new and challenging problems in a complex setting which is always in transition. Its in-depth contacts with the AHC and other influential Afghans who are already leaders in their regions, and will eventually become part of the transitional government, are impressive. These relationships represent months of working together, establishing mutual trust, and hammering out practical working arrangements which are feasible only in the Afghan context.

Looking to the future, the assessment team is concerned that the project not lose the momentum already built up, or more importantly have a rupture or hiatus. The MSH project PACD is September 1989, and will occur in the midst of the transition period at a time when many health delivery activities supported by the project will be functioning inside Afghanistan.

The assessment team has concluded that a strong operational role for the contractor (MSH) is absolutely essential at this juncture. As mentioned earlier, MSH is not only responsible for technical advice, but also for operations. In addition to the 5 technical assistance team members, MSH/Peshawar has a staff of 21 Pakistanis and 84 Afghans to carry out the operational/logistics and monetary functions (see Table 2). Although MSH has been very successful in designing and establishing workable operational programs to help deliver health care services in Afghanistan, progress has been much slower in terms of institutional development of the AHC to enable it to manage and administer these activities on its own. This aspect will take more time. An exception to this is the AHC's Training Center, which is a good example of an organization which can easily be transferred to a more permanent government service at the proper time.

Given the complexities of the local scene and the operational role of the MSH team, and looking beyond FY 89, it will be very difficult to field another team without loss of momentum, given the time needed to gain experience, establish contacts, and follow the rapidly evolving situation inside Afghanistan. A break in continuity, rupture in stock, equipment, supply of medicines, and salaries of the BHWS and other key members in the primary health care pyramid would disrupt vital health services and create an enormous credibility problem with the population. Therefore, the team has concluded that it is essential that the present MSH team be continued in the next phase through FY 92. (This subject will be discussed further in the AAM amendment.)

The assessment team agrees with the \$20.6 million program level (Option A in the second year work plan, and included in the AID/Representative's request for FY 89 funds). It also supports the strong impetus given to training and equipping BHWS as well as the opening of clinics, health centers, and area hospitals in areas where this is administratively possible. Such help is vitally needed given the lack of any rural health facilities inside Afghanistan and the tremendous need of the population for basic health services.

Accomplishments to date under the project are impressive, both operationally and administratively, with most of the second year work plan goals achieved (see Table 1: Planned and Achieved Outputs of the Health Sector Support Project included in the Executive Summary).

TABLE 2: STAFF ON MANAGEMENT SCIENCES FOR HEALTH, PESHAWAR PAYROLL

(AS OF JUNE 1988)

	AMERICAN	FRENCH	BELGIAN	AUSTRALIAN	SPANISH	PAKISTANI	AFGHAN
<u>MSH TEAM MEMBERS</u>	3	1	1	1	-	-	-
<u>MSH MAIN OFFICE</u>							
<u>Permanent</u>							
Liaison Office	-	-	-	-	-	7	9
Finance	-	-	-	-	-	3	-
Program	-	-	-	-	-	-	2
Immunization	-	-	-	-	-	1	-
Translator	1	-	-	-	-	-	-
Trainee Clerks/ Computer Operator	-	-	-	-	1	-	4
<u>MEDICAL WAREHOUSE</u>							
Permanent Employees	-	-	-	-	-	8	16
Temporary Employees	-	-	-	-	-	2	4
<u>MONITORING UNIT</u>							
<u>Permanent Employees</u>							
Peshawar Based	-	-	-	-	-	-	5
Border Based	-	-	-	-	-	-	10
<u>Temporary Employees</u>							
Border Based	-	-	-	-	-	-	8
Inside Monitor	-	-	-	-	-	-	26
<u>TOTAL</u>	<u>4</u>	<u>1</u>	<u>1</u>	<u>1</u>	<u>1</u>	<u>21</u>	<u>84</u>
<u>GRAND TOTAL</u>							

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SOURCE: MSH, Peshawar, June 1988

In preparing the AAM amendment, the team will not only look at the enormous unmet nationwide need for preventive and curative health services, but also at the capacity to provide and operate additional services over the next four years (FY 89-92). In the short to medium-term, determining the realistic potential capacity for expansion of primary health care services in Afghanistan is perhaps more relevant than focusing on total national demand. This point is particularly pertinent due to the limited amount of trained manpower, infrastructure, management and administrative capacity likely to be available during this period.

Given the present pace of project activity, additional funding will be absolutely necessary not later than the first quarter of FY 89. (This subject is reviewed in detail in Section 4.5 below.) AID management will need to consider the risks of disruption of vital basic health services if some of the FY 89 funds now planned for are not made available in the first quarter of FY 89.

Given the uncertainties, it might be wise to consider additional funding in FY 88 to assure that unforeseen delays in availability of FY 89 funding will not damage the project. (For example, although the total authorized under the project is \$16.6 million, only \$15 million has been committed to date. If further FY 88 funding can be found, such action would increase the funds available to MSH by \$1.6 million.)

In view of the present and growing work load for the MSH team as the training, developmental and supply activities become operational (i.e., one or two new tanzeems joining and new regional area programs requested), the MSH team will need to consider ways to increase its operating capacity/productivity, e.g., by hiring highly qualified Afghan professionals (acceptable to the AHC) who could help with the implementation of the operational programs. The Afghan professionals would also benefit from working directly with the highly skilled and experienced MSH team members. Further expatriate help might also be considered if new functions are added, e.g., if the procurement responsibility is changed by AID so that MSH rather than AMEG (AID contractor) does the purchasing. Other options should also be considered, including use of qualified, experienced short-term TA to help on specific high priority tasks, stronger backstopping from MSH Boston, and so forth.

The team was impressed with the importance of intra-team communications brought about by the interrelationships and interdependence of the principal components of the MSH program. For example, if training gets ahead of refurbishing or establishment and staffing of clinics, health centers, and province hospitals, BHWS will not have the necessary supervision and backup/referral support. The outreach of the fixed structures will be limited, if BHWS are not available. Procurement is intimately related to timing of first time and resupply needs of the BHWS, clinics, health centers, hospitals, and so forth.

Further, changes in program implementation and addition of new activities impact directly on present and future fiscal requirements, highlighting the need for frequent and regular cross-communication. Estimates of accrued expenditures must keep up with acceleration and deceleration of project programs and activities.

The fluid nature of the evolving security, social, economic and political situation in Afghanistan, all of which affect project operations and future plans, further underlines the importance of close and regular communications. Given the heavy work loads of the individual team members in their respective areas of responsibility, it would appear necessary to make special efforts to assure that this aspect is not neglected.

The team found that USAID, the MSH team, the AHC, and the Government of Pakistan, had close working relationships, and that the USAID support was very good. The USAID Project Manager has done an excellent management job in a difficult and complex area.

4.1.3 Recommendations

1. AID should start immediately to assure (insofar as possible) that there will be no hiatus between the present project activity completion date (PACD) of September 1989 for the Health Sector Support Project which is growing rapidly in terms of cost, and the major follow-on activities which will be addressed in the revised AAM.
2. AID management should take the necessary steps to make available, early in the first quarter of FY 89, some of the FY 89 funds already included in USAID planning to avoid ruptures of stock, elimination of medical services, creation of distrust, and so forth.

If this is not possible, additional FY 88 funds should be made available to diminish this risk. For example, the original project authorization for the Health Sector Support Project was for \$16.6 million of which \$15.0 million has been obligated. If FY 88 funds can be found, AID might wish to consider making available the remaining \$1.6 million authorized.

3. MSH should redouble its effort to hire highly qualified Afghan professional staff, as needed, and consider other options to help it increase its operational capacities and meet its growing work load demands which will peak in FY 89. If not already available, appropriate job descriptions should be prepared and the jobs advertised. Carefully selected short-term TA for specific priority tasks might be considered.

4. Given the rapidly changing situation in Afghanistan, the growing work load, and coordination demands, MSH should emphasize cross communications on a regular, frequent basis (both in meetings and informally), especially given the interrelated nature of the various components of the Afghan Health Sector Support Project.
5. Given the complexities of the Health Sector Support Project and the local scene and the operational role of the MSH team working with AHC, in order to avoid a serious loss of momentum (given the time which would be needed for a new team to gain experience, establish contacts, gain the confidence of the Afghans, and follow the rapidly evolving situation inside Afghanistan), AID should continue the present MSH team through the end of the project extension to FY 92 being proposed in the AAM amendment.

4.2 Health Services Inside Afghanistan

4.2.1 Context (Findings)

In the case of Afghanistan, where much of the health infrastructure has been destroyed and personnel have been displaced, killed, or have emigrated, there are serious shortages and gaps in all levels of health care. Therefore, the major objective of this project has been to expand health services inside mujahideen-controlled areas of Afghanistan. Following initial discussions with Afghan health experts and political leaders, needs were identified and a strategy developed. The priorities were for expanded medical and surgical care for war casualties and for expanded general health care for the civilian population. Based upon experience in Afghanistan, the need for short-term training in order to get services into the field rapidly and discussions with other service providers, the Basic Health Worker (BHW) model was approved by the AHC and AID. This BHW model would provide the mechanism for the expansion of health services for both the mujahideen and civilian populations, regardless of party affiliation. During the first year of project activity, emphasis was placed on the preparation of BHWS for assignment to the field. The first class of 100 BHWS graduated in July 1987. By July 7, 1988 a total of 820 BHWS will have graduated. The project estimates that of the current graduates (580), 70 percent or 406 BHWS are now working inside Afghanistan. Steps are being taken to insure accurate and prompt reporting when a BHW does not remain actively on the job.

There have been two refinements of this initial strategy. The first resulted from a review of green books (field reports) from BHWS and other medical personnel. Based on these reports, it was determined that trauma cases had been over-estimated and that, in fact, these represented only 4 percent of the typical caseload. This information provided further justification for the BHW

approach. The services provided by BHWs are estimated to cover as much as 60 to 70 percent of the reported health problems among mujahideen and civilians. (This may be somewhat of an over-estimate since pregnancy, gynecological, and birthing-related problems generally are not included.)

The second refinement has been the adaptation of the Area Health System model by the leadership of the AHC and some area commanders. This model is the health services pyramid with primary health care workers operating from clinic bases which provide basic curative services and referrals up the pyramid to increasingly sophisticated secondary and, finally, tertiary services.¹⁴ Area health systems would also include necessary support services such as administration, training centers and supply depots.

14 Although flexible in design, the three levels of service delivery under the project are defined as follows:

Health Posts: (no beds)

1 BHW

Clinic: (no beds)

1 paramedic*

1 nurse

1 laboratory technician

2 watchmen

1 cleaner

Health Center: (1 to 10 beds)

2 nurses

2 paramedics*

1 laboratory technician (??)

1 x-ray technician (??)

1 cleaner

3 watchmen

1 cook

Area Hospital: (10 to 20 beds)

2 doctors

3 nurses

4 paramedics*

2 lab technicians

2 dental technicians

4 x-ray technicians

2 anesthesia technicians

4 watchmen

1 cook

1 cook helper

3 cleaners

* The term "paramedic" is used here to describe a health professional who has had from 12-18 months of intensive curative and preventive medical training (including hands on work) who is capable of managing a clinic.

This regional/area model is currently under implementation in two areas: the North East, under Commander Masood, and the North West, under Commander Ismael Khan. The South East area, Paktia, is expected to be the next to organize service delivery along the lines of this model. The model also incorporates an important lesson from pre-war Afghanistan concerning the need for decentralized organization of health service delivery.

The immunization program has been initiated. A country program plan has been prepared. AHC with the assistance of AVICEN has completed the training of the initial 21 vaccinators. UNICEF is providing vaccines and supplies. The project is providing cold chain equipment and supplies. The first vaccinator teams of five each will leave in early July for the four provinces that have been selected for the initial campaigns. Information from PVO programs is surprisingly good regarding maintenance of cold chain. In all campaigns 3M monitor cards were used and, in most, freeze watch indicators were also employed.¹⁵ The AHC program has been designed taking this experience into account.

In many areas, the BHW is the only source of health services, which is not a desirable situation because these primary level workers depend upon the referral pyramid. Currently, supervision is being accomplished by MSH monitoring team visits, commanders' organizational control, and interviews in Peshawar when the BHWs come out for resupply. Candidates for BHW training are selected according to project criteria by commanders from the mujahideen and approved by the tanzeem. To date, BHWs have been recruited and assigned on an equal basis by tanzeem. More recently, a criteria for geographic coverage within each tanzeem was added. Candidates for nurse and doctor positions are selected by the AHC Medical Subcommittee from qualified candidates who have the approval of the tanzeem and commander. Although it has been standard practice in Afghanistan and among tanzeems to provide disability or life insurance through the employer, direct MSH employees including AHC employees, do not have this benefit. Employees of the tanzeems are covered in this respect.

To date, bulk packaging has been utilized for BHW, clinic and hospital supplies. Course-of-treatment repackaging for the BHWs is planned by the project in the near future. Under current conditions, this added step would be burdensome and of questionable cost-effectiveness. As additional BHWs are assigned and resupply requirements grow geometrically, it is doubtful course-of-treatment repackaging will even be feasible.

¹⁵ Cita, Kathleen, A Report on Vaccination Progress in Resistance Held Areas of Afghanistan, UNICEF, 1988.

Finally, as information has been received from the field, feedback loops have been developed. For example, the contents of the BHWS' supply kits have been changed based on utilization rates and reported case loads. Analysis on a sample basis of the data in the green books has started. Once this initial analysis is complete, adequate personnel should be employed to maintain the system. This information system should be utilized by the AHC and MSH to provide feedback information for changes and corrections in the training, supply, logistics, and other support activities.

With regard to specific outputs, data in Table 1 illustrates what has been achieved to date as compared to the goals planned under the Year 2 Work Plan.

Since this assessment is taking place in June and we are measuring against the Year 2 Work Plan (ending September 1988), there are three months of the year remaining to complete planned objectives. Clinics have been and continue to be the major felt need from the field. Therefore, the project has not pushed to provide hospitals, especially since there have been procurement problems to be worked out which may have meant delays and loss of credibility when requests could not have been filled. These procurement problems have now been successfully resolved. In the meantime, the project has used this time to establish the capability to later upgrade some clinics to the district hospital level. Delays in supply and resupply of clinics has been caused by time required to establish an adequate quality control certification mechanism for medicines purchased in Pakistan. Our review of work plan objectives for BHWS and clinics resupplied indicated these were set unrealistically high. The project should come close to reaching approximately two-thirds of the stated objectives, which is a very satisfactory performance. Similarly, the area health system objectives were set realistically high for Year 2 of the project.

Reports from the field indicate that due to the presence of the BHWS, there has been less need for an improved evacuation system. Thus, this activity was dropped from the work plan.

4.2.2 Conclusions/Lessons Learned

The assessment team was told repeatedly by representatives from various constituencies both project and non-project related within the health sector, that progress under the project has been substantial. The team's assessment is that implementation performance has been outstanding. This success can be measured in terms of the relatively short time used by the project to have BHWS assigned, supplied, and functioning in the field. Likewise, the project has been able to establish effective working relationships and recruit quality project personnel rapidly. Perhaps one of the most significant achievements has been the general acceptance of the BHW and the Area Health Systems model at a level which indicates

understanding and commitment on the part of the AHC technical and executive leadership and some area commanders.

In general, the project is on schedule in achieving most targets. There have been some delays, discussed in more detail in Section 4.3, caused by procurement problems. These have now been adequately resolved. It was expected that the area health system development would proceed more rapidly than has been the case. Although progress has been substantial, future expectations should be for a slow but steady pace.

In essence, the project has substantially expanded the availability of health services which address a significant but not quantifiable portion of the major disease and emergency care needs. One of the important lessons learned was that health care services, even in a warlike/hostile environment, can include a large measure of non-military health care services for the civilian population, and this was achieved by working with the AHC and local commanders to include these subjects in the training curriculum for the basic health care workers, and providing them with appropriate medical supplies. Geographic coverage was slower to be organized but is now a priority. Based upon current plans, it appears that there will be a need for female and mid-level health personnel as the Area Health Systems Model is implemented, health services in Afghanistan expand, and MCH services are established. Sufficient numbers of qualified personnel are not likely to be available. In addition, the shortage will be greatest in the doctor and nurse categories and for BHW candidates in those provinces where the educational level is very low, e.g., the South West Area. Analyses must be carried out to confirm these estimates and allow for adequate planning for recruitment and training to fill field requirements.

4.2.3 Recommendations

1. Continue as planned with the implementation of Area Health Systems, including the assignment and support of BHWs, clinics, and hospitals. Assistance should be provided to those areas where commanders or jirgas have shown strong organizational effectiveness, the essential criterion for the development of Area Health Systems.
2. It is essential that the project give priority to the distribution of personnel and facilities based upon population and needs criteria.
3. The project is encouraged to move ahead as rapidly as possible with the design and implementation of the preventive health program in MCH. The first step should be to develop a country program or strategy for expanding MCH service availability and utilization, similar to that which has been prepared for immunization. A specific package of socio-culturally acceptable target

interventions should be emphasized. We suggest that the use of midwives (dais), female nurses, and female BHWs be explored. The Preventive Health Division will require additional personnel and resources in order to accomplish this. The implementation of the malaria preventive health program should not start until country program plans have been prepared. We see this happening sequentially with MCH beginning first.

4. The project should proceed rapidly to incorporate the one or two new tanzeems into field operations.
5. Additional personnel should be hired to complete the analysis of the management information system, including the backlog of green book data, by September, 1988. Rapid and reliable analysis of the information on the immunization campaign, especially regarding maintenance of cold chain, will be important prior to initiating full scale programs.
6. Where an Area Health Officer can establish need, the project should appropriate transportation (or money for their local purchase) to be used for supervisory purposes. We believe that only Area Health Systems will be organized sufficiently to allow for the appropriate controls and maintenance of transportation in the field. Likewise, the provision of ambulances should be arranged through Area Health Officers where need and sufficient management and maintenance capability can be demonstrated and adequate roads exist.
7. We suggest the project consider a pilot test of course-of-treatment repackaging prior to initiating it on a full scale.

4.3 Procurement/Logistics

4.3.1 Context (Findings)

The team has discussed procurement/logistic practices with AMEG and MSH staff. The MSH warehouse has been inspected to check on storage and repackaging methods and effectiveness. The team has not been able to inspect border or cross-border logistic operations.

The procurement procedure for medical supplies and equipment has been complicated by having one contractor (AMEG) in charge of procurement itself and another contractor (MSH) responsible for all other aspects--including choice of the medicine to be purchased, its safety, storage prior to issue and similar responsibilities for medical equipment. This situation is further complicated by physical separation of the procurement function (Islamabad) and the

medical managers (Peshawar) with difficult and uncertain communication links. In addition, the funding for this procurement is in the MSH contract although the function is performed by AMEG, thus splitting management responsibilities. Also, as pointed out by the team which assessed the Commodity Export Program, "Health project procurement is already responsible for about 50 percent of the AMEG procurement workload and is the activity likely to expand the greatest in the future."

Under these circumstances, there were problems getting the initial procurement underway, no provision for warehousing, a new and unexpected requirement to inspect local drug suppliers for good practices, and delays in delivery. It has been particularly difficult under split responsibilities to match deliveries with departure of teams of users for Afghanistan.

MSH filled the warehouse gap, employed two special consultants to inspect suppliers in Pakistan for good practices, has hired an additional full-time employee who has been assigned responsibility for MSH's oversight and management functions for medical supply, and has made a major effort to improve procedures and communications with AMEG so that procurement actions will be better matched with delivery requirements. Since February 1988, AMEG has had a full-time professional, assisted by three local employees, assigned to procurement for the Health Sector Project. New forms and procedures are now in place and communication has been improved.

Timing of delivery at the warehouse for proper handling, and procurement delays are problems requiring immediate remedial action. Expansion of the warehouse to meet future anticipated deliveries and storage is essential. Revised procedures currently being worked out should handle the timing problem, while a funding request for additional warehouse space has recently been approved by the AID/Rep Project Officer.

4.3.2 Conclusions/Lessons Learned

One of the lessons learned was that by working with AHC, with Alliance party commanders, and with the Pakistan government, it has been possible for the contractor to establish a system for not only procuring the equipment, medicines and other supplies needed to support the BHWs, clinics, health centers and area hospitals, but also for delivering them inside Afghanistan. This has required close cooperation with all parties concerned.

While adjustments (delays) in the departure of new clinic staff for Afghanistan due to the shortage of a small number of commodities is a current problem, appropriate corrective action has already been taken. The next major procurement action seems to be in training. Earlier difficulties have been dealt with adequately. Shifting the procurement function from AMEG to MSH will increase the costs in the Health Support Project by the cost of its administration (an

estimated \$200,000 annually). The possible glitch in funding availability discussed elsewhere is the major cloud on the horizon. While other unanticipated problems will no doubt arise, current staffing and procedures appear adequate to handle them effectively.

4.3.3 Recommendations

1. That in agreement with the CEP Assessment team's recommendation (4) "AMEG be relieved of the requirement to procure for the Health Sector Support project as soon as alternative arrangements can be made and put into effect."
2. That in order to make the transition in 1. above as smooth as possible, the major procurement orders necessary to support program activities under the Health Support Project through calendar 1989 be issued by AMEG under current arrangements in the summer of 1989, so that no gap in medical supplies will occur during a shift in management arrangements.
3. That the contractor for the Health Sector Support Project (MSH or any successor) handle the health procurement function to maintain full management control and bring health expertise to bear most effectively.
4. That a contract procurement officer, plus the necessary local staff, be recruited and hired by MSH or its successor when funds are available following review of the AAM Amendment and in careful coordination with AMEG.

Note: With regard to its recommendation on health project procurement, the CEP assessment team stated the following:

Health project procurement is already responsible for about 50 percent of the AMEG procurement workload and is the activity likely to expand the greatest in the future. Furthermore, health logistics systems are traditionally separated from other logistics systems because of their highly specialized nature. We believe, therefore, that the health procurement function should be shifted from AMEG soon--before the big crunch comes with repatriation. We leave to the health project assessment team (to begin June 1, 1988) to recommend whether the procurement should be taken over by MSH or some other organization.

4.4 Training and Education

4.4.1 Context (Findings)

During the first year of the project, emphasis was placed on the formation of basic health workers (BHW) for assignment to the field. This meant that within the first eight months of project operations the following activities were completed: BHW curricula developed; list of medical supplies for training developed and procured; BHW criteria developed and coordinated by clinics, logistics, and other concerned AHC Departments; training, monitoring and evaluation plan developed and implemented; and classrooms, clinics, and residential facilities established in the four participating mujahideen camps. These were accomplished and the first BHW training session was initiated in April, 1987. This session lasted ten weeks and contained 100 participants, 25 from each tanzeem. These graduated in July, 1987. Since that time, three additional training sessions of 12 weeks each have been held (including the one now underway) of 240 participants each, including 60 from each tanzeem. On July 7th, when the most recent class graduated, 820 BHWs will have received training through the project. The BHW manual has been prepared and publication will be completed in September, 1988.

During the first year the Training Center was established. The Center is responsible for curricula development; training; management/administrative support for training programs; seminars and workshops; refresher training short courses; translation and publication of training and health education materials; the reference library; the public education program; testing and certification; assessment of training; and coordination of training objectives with field operations.

The project has received a proposal from the Area Health Officer of the North Eastern area to establish the first area Training Center. Two additional area centers and mobile training units are proposed for implementation over the next 15 months.

Feedback information and experience gained during the first training session has been utilized. The training session was extended by two weeks to accomplish the BHW training objectives. Similarly, based upon analysis of BHW locations, geographic coverage was added as a criteria for the selection of new BHWs. To date, there has been no analysis of numbers trained to future field requirements. Feedback information covering the assessment of BHW performance and relevance have not yet taken place. The project plans to send out the first performance assessment teams during the last quarter of this year. They will assess the relevance of the training to the actual on-the-job performance of BHWs and interview

patients and community leaders for their assessment of the services provided. This information is essential for planning and for providing information on content and emphasis of the BHW training program.

During this second year of the project implementation, additional training courses have been developed and implemented. The first is "buddy care" which is a two-day short course for mujahideen in first aid (how to stop bleeding, immobilizing injured, and transport to medical services). The project experienced considerable delay in the start-up of the buddy care program. The compression bandages given to each mujahid completing the course were not available in Pakistan and had to be procured from the U.S. This required some six months to obtain bandages by competitive procedures. Full active coordination between the camp commanders and the tanzeem committees is essential but was slow to develop, which delayed the nomination of participants. It was also necessary to change trainers from BHWs to first aid trainers in order to improve training technique and trainers credibility among the students. The buddy care training is now underway and appears to be fully subscribed and appreciated by the trainees. To date approximately 3,500 mujahideen have been trained with an additional 2,000 expected by the end of September. The project will not reach the Year Two Work Plan objective of 20,000. In retrospect, this figure now seems unrealistically high.

More recently, short-term refresher training courses have been developed by the AHC Training Center. Curricula are prepared for courses of the following durations: nurses, six weeks; doctors, three months; a condensed three week course for doctors coming in for resupply; and BHWs, two weeks. Refresher training will commence during August, 1988. Participants will consist of Afghan health staff returning to Pakistan on resupply visits and new hire nurses and doctors.

The project arranged for the first class of 24 vaccinators for the immunization activity to be trained by the Afghanistan Vaccination and Immunization Center (AVICEN), a group which has trained vaccinators for PVO and UNICEF immunization programs. Twenty-one have graduated. The succeeding classes of vaccinators for the AHC immunization program will be trained by the Training Center using the AVICEN curriculum.

The adoption of the vaccinator curriculum is one of two instances where curriculum sharing between organizations has occurred. The other is the plan by Mercy Corps International to use the AHC curriculum for BHW training in its training program.

Field operations for the health education activity will begin during the next quarter. To date, content and messages have been developed and materials have been prepared. However, the program lacks an overall country strategy, although the idea is to have

health education become a part of the responsibilities of all health personnel assigned inside Afghanistan. Since all AHC health personnel are males, current plans do not directly address the need to direct health education towards the female population as well.

The BHW students reported and the team confirmed some basic water and sanitation problems in the training and dormitory facilities in the camps. It seems somewhat inconsistent to teach the BHWs good water and sanitation principles and then provide them with unsanitary living and educational facilities. These problems need to be resolved as soon as possible.

4.4.2 Conclusions/Lessons Learned

One of the lessons learned was that institution building could begin, early in the project life, even given the dangers and uncertainties during the fighting and the speculation about the future working with Afghan professionals appointed by the AHC and financed under the project, e.g., the Alliance Training Center.

Among the project's major accomplishments are the establishment of the outstanding AHC Training Center and the astoundingly rapid development of the BHW training program. Both of these were achieved while maintaining excellent quality of organizational control, technical content, and teaching methods. The Training Center is certainly a needed institution capable of making the transition into a peacetime Afghanistan.

A health education program will be one of the most effective available means for reaching the female Afghan population and, therefore, planning for this activity should be speeded up. This must be done carefully, with socio-cultural sensitivity. The first priority should be the development of a country health education plan. Based upon reported recent negative reaction to RA programs for women, it would be a mistake to directly target women. However, maternal and child health and nutrition messages should be emphasized. This program will be a challenge given the current conditions in Afghanistan and the low literacy rates. However, in addition to one-on-one communication, radio or VOA is available and we understand women listen to it. Other delivery mechanisms could be explored, too.

The activities of the training component are on schedule except for the buddy care program which should now be able to make up time and meet original objectives.

Other requirements identified by the AHC Medical Subcommittee are: upgraded hospital-based training facilities for doctor, nurse, and BHW refresher training; training courses for medical technicians; and training for female nurses, BHWs, and traditional midwives (dais) to provide the missing MCH services.

It would be preferable to upgrade one existing institution as the teaching hospital for all health personnel. No analysis of the need and current availability of trained medical technicians was presented. The feasibility of the latter (training of female BHWs, nurses and dais) will improve as training activities move inside Afghanistan since females generally would not be allowed to travel outside their village, even for short-term training programs.

In general, this should be a time of both consolidation of previously instituted activities and initiation of several new planned training activities, including the start-up of BHW training activities for at least one and perhaps two new members of the AHC. The training component has a considerable work load to accomplish during the remainder of Year 2 and Year 3. In addition, duplication of effort with PVO training programs should continue to be avoided.

4.4.3 Recommendations

1. Since health education does represent an important available mechanism for reaching the female population and improving their health status along with that of their children, the health education activity should receive emphasis during this last quarter of Year 2. The AHC Training Center should establish a Health Education Unit to design and implement this program. New positions created might be an opportunity for the Center to recruit its first female employee. Technical assistance from organizations with experience dealing with similar situations and population characteristics would be appropriate as well as a visit to successful, similar efforts in other countries. For example, in some Islamic countries the mullahs now stress hygiene in their homilies. This is considered consistent with Islamic principles. Also, a health education component should be added to the refresher training courses.
2. This Health Education Unit may want to consider mounting a program to inform the population about the danger from unexploded anti-personnel mines and how to avoid these problems. Clear pictures of the mines and messages to stay away and report unfamiliar objects to parents or authorities have been successful, especially with children, in other countries.
3. The project should establish training courses for female BHWs, dais, and nurses, within the context of the MCH strategy recommended in Section 4.2.3 above. The team believes this is warranted because the presence of female health personnel within the system will promote the expansion of much needed MCH services inside Afghanistan. To accomplish this very difficult objective, it will be necessary to scrutinize every aspect of the operations and

programs of the Training Center in order to identify barriers to female participation. Likewise, innovative recruiting methods will have to be devised and utilized with caution and sensitivity.

4. The assessment team concurs in the project plans to establish area training centers and to move forward with the mobile training units and field training assessment teams. The team sees these activities as important from an institution building perspective as well as essential means to making possible female participation in training programs and to making possible qualitative evaluation of project outputs.
5. Since the BHW training course teaches basic water and sanitation fundamentals, it is important that the training camps be provided with basic water and sanitation facilities with financial or in-kind participation by the tanzeems.

4.5 Fiscal Management and Administration; Program Planning

4.5.1 Context (Findings)

The team has had extensive discussions with the MSH staff charged with fiscal management and administration. Discussions on fiscal matters have also been held, inter alia, with each AHC party chairman.

The cross-border nature of this project has made fiscal management and administration unusually challenging. The absence of the usual government to government framework has had many implications for project financing and administrative arrangements. This is a common factor for all AID/Rep projects in Afghanistan but must be kept in mind in dealing with performance in the health area as well as the others. There are no counterpart institutions or sources of local financing in the usual sense.

Under these circumstances, AID/Rep activities have been in support of those institutions and groups judged able to advance the objectives of the project. As a result, while the Alliance Health Committee has been a primary vehicle for support, other mechanisms have also been used. In addition, the contractor, MSH, under AID/Rep guidance and supervision, has operated more directly with the Afghans as groups rather than, as more typically, as institutions. This in turn has shaped the way funds are administered and transferred. For example, the \$15 million funded to date has been obligated under grant amendments to the Cooperative Agreement rather than the more typical mechanism of a Project Agreement (Proag).

MSH has tried to strengthen the financial and administrative ability of the AHC, to the extent practical, but there are very real limits on how much the AHC can handle currently. MSH has provided financial support directly to the AHC but has not been able to channel financial support through the AHC. To date, there are only two people on the AHC staff charged with financial management and administration, and they have limited financial training and experience. Technical assistance, therefore, has had little practical impact in the finance area. AHC has not provided financial contributions to the project nor managed the AID/Rep contributions. Payment of salaries and project costs beyond those of the AHC itself have been made by MSH directly rather than through the AHC. This has been for both program and practical reasons. While the AHC has set policy and broad objectives, the AHC has not had the staff skills necessary to manage USAID financing for project activities other than the AHC itself, and some recipients of project funds have not been under the AHC rubric.

While this has resulted in atypical management and financial procedures, MSH has been rigorous in its financial control system. The procedures used are designed carefully to get payments delivered to those providing services. In fact, the direct MSH to recipient system probably lessens the risk of diversion of funds, since MSH staff physically deliver money to the specific recipient groups and individuals. Close controls are maintained on payments made prior to departure for Afghanistan. Initial receipt is carefully documented. Again, however, in a cross-border situation, an audit trail in the usual sense is not practical. (Audits apply up to the border and not beyond at the present time.) A monitoring system is in place to check on program performance, and delivery of supplies and financing inside Afghanistan when and where possible. (See Section 4.6 for further explanation of the current monitoring system.)

Comment on Program Planning: Planning has not moved ahead in the AHC as had been hoped due to the initial emphasis on getting implementation activities underway as quickly as possible and due to staffing delays. Recently a person to take charge of this AHC function was chosen, and the need to look ahead is reinforced by the political and military transition taking place in Afghanistan itself. While MSH has done considerable intermediate-term planning, "aggressive implementation" has necessarily taken higher priority.

4.5.2 Conclusions/Lessons Learned

The cross-border nature of the program and the absence of official government counterpart institutions make major modifications in typical fiscal management and administration essential. In addition, the limited capacity of the AHC in the financial area despite technical assistance efforts has been a major constraint. MSH has been very realistic in its approach to fiscal management and administration. A bonus from the technique used has

been the flexibility to channel funds when necessary directly to regional groups under strong commanders who have mounted structured regional health systems. MSH has maintained tight control over the flow of funds to initial recipient groups and individuals. The major shortfall has been in the inability to build an AHC financial and administrative capacity strong enough to be the conduit and administrative manager of funds beyond the requirements of the AHC itself. To sum up, the team feels that MSH has done a very good and imaginative job in the field of fiscal management and administration.

With regard to Program Planning, MSH has done an excellent job of continuous feedback program planning. The use of the monitoring system to make immediate changes where required is a good example. Long range planning is extremely difficult but on intermediate planning combined with reprogramming and revised activities, MSH deserves high marks. The AHC planning function has not yet been effective. However, current circumstances which call for planning for phases of future activity during the transition process along the lines being developed by the AHC Medical Sub-committee, may lead the way to future improvement in planning.

4.5.3 Recommendations

1. That additional incentives (such as training, workshops and planning technical assistance) be examined to encourage AHC action to strengthen planning, fiscal management and administration.
2. That the current need to develop plans for future activities be used to encourage the AHC Medical Sub-committee to continue to develop its ideas for the future, including costs estimates.
3. That as the situation inside Afghanistan permits, efforts be made to lengthen the audit trail.

4.6 Monitoring, Evaluation, and Accountability Measures

4.6.1. Context (Findings)

The nature and scope of the monitoring system for activities carried out inside Afghanistan is one of the boldest and most imaginative measures taken in the project to date.

Teams of Afghan monitors (at present Americans are restricted from travel inside Afghanistan or to sensitive border areas) hired by the project have reported about their trips through seven provinces since December, 1987 to the present. In these areas 158 BHWs and 11 clinics of the project are located. These provinces include Logar, Kunar, Paktia, Nangarhar, Ghazni, Kabul, and Kandahar. Trips have been conducted primarily during the winter,

and thus heavy snows have limited a complete survey in some of these locations.

Results to date are as follows:

From 158 BHWS:	65 BHWS are functioning	41%
	64 BHWS are not functioning	40%
	29 BHWS have not been surveyed	19%
		<u>100%</u>
From 11 clinics:	9 clinics are functioning	82%
	1 clinic is not functioning	9%
	1 clinic has not been surveyed	9%
		<u>100%</u>

These initial results are skewed because the first BHWS sent by the project into Afghanistan entered as individuals in advance of a functioning health system. In addition, because of the difficulties the monitors have encountered in locating individual BHWS (lack of precise identification in the early classes, difficulty in gaining access to combat areas, and the mobility of the local mujahideen commanders to which the BHWS have been assigned), AHC and MSH feel that some of those currently classified as "not functioning" may still be in the field and will come in for resupply of medicines, and so forth, in the next few months. Therefore, the percentage in the BHW "functioning" category is expected to rise. At the end of the grace period of a few months, concrete steps will be taken to remove those BHWS not accounted for from the roles (i.e., salary support, medical supplies, etc.).

The team agrees with the MSH team assessment that the BHW retention rate and effectiveness will increase as more functioning clinics supported by health centers and area hospitals are established. Another encouraging aspect of the monitoring process to date, in addition to the substance, is that the reports generated are clearly not a whitewash. There is every indication from follow-up interviews that what is being reported reflects reality.

Also encouraging is the fact that despite the real risk borne by each monitor during his travels through Afghanistan, there have been no deaths or injuries reported among them to date.

Presently there are other teams of monitors working in nine more distant provinces who have not reported back yet. These provinces include Baghlan, Balkh, Samangan, Bamiyan, Fariyab, Jawsjan, Laghman, Takhar, and Wardak.

Monitoring trips are often more than one month in length, depending upon distance, difficulty of terrain, and so forth. Commanders, BHWS, and clinic staff are interviewed in detail about their activities and needs, and it appears that the commanders are especially appreciative of the monitoring process.

Recently there have been attempts made to utilize the services of one monitor to check up on a number of different groups' health workers in a given area. This is indeed a positive step towards coordination between various organizations working cross-border, and it should be encouraged.

With regard to monitoring the movement of supplies to the border and beyond, the system in place is effective. A monitor checks each movement of supplies from the project warehouse in Peshawar to a party warehouse or depot near the border. These individuals send in weekly reports and often assemble in Peshawar for meetings with project staff about their important role. At the border two additional monitors check to see that supplies are correctly loaded for trans-shipment; major crossing points include Terimangal, Miram Shah, Torkham, Bajour, and Chitral. Lastly, a truck or mule driver is hired as another monitor who checks the shipment's progress to its correct destination in Afghanistan. Many of these networks are well established and are made up of close acquaintances.

As the project increases in size, every effort will be made to improve monitoring feedback effectiveness in order to enable necessary project modifications. This will include stopping payment and delivery of supplies to nonfunctioning BHWs, bringing problems discovered to AHC's attention, and devising new or modified solutions to common problems.

4.6.2 Conclusions/Lessons Learned

Congratulations are very much in order for the project's monitoring system. Its design and utilization are impressive.

Evaluations should continue to take place as an element of project re-design, as with this team's assessment. Given the major changes expected in the coming months, both inside and outside of Afghanistan, the plan is to carry out evaluations or assessments each year. Specific focus for smaller evaluations should be upon special undertakings of the project, such as immunization, health education, nutrition, etc. Capacity for such evaluations should be developed within the project itself, or expertise from MSH/Boston should be utilized.

Project accountability, as usually understood, has been pushed as far as possible, given the limits on travel which are in force. It is anticipated that this important issue will be able to be better addressed in the future as the situation changes, more Afghans return home, project activities expand, and more expatriates are able to work within Afghanistan itself.

4.6.3 Recommendations

1. Every effort should be made to maintain the monitoring system's effectiveness in order to make necessary program and activity modifications; these include ceasing payment and delivery of supplies to nonfunctioning BHWs, bringing problems discovered to AHC's attention, and devising new or modified solutions to problems.
2. The current effort to exchange monitoring results among the various groups carrying out cross-border activities should be pursued actively.

4.7 Coordination With Other Contractors and Grantees (PVOs)

4.7.1 Context (Findings)

The project has been working informally with PVOs since it began its work in 1986. Although the MSH team was looked at with considerable suspicion when it first started operations in Peshawar, this has decreased as work has progressed.

Indeed, MSH has recently been asked to become a member of CMC (Coordination of Medical Committees), and it has accepted. MSH is the first non-PVO member of CMC. CMC, which was established informally by a few PVOs working cross-border with Afghans in 1985, is now made up of more than 11 international health-related PVO members from the USA, France, Belgium, and Germany which are based in both Peshawar and Quetta. Its operations are financed by membership dues (\$5,000 annually) plus UNICEF, Norwegian, and AID grants.

With regard to the work of the CMC, the slowly achieved gains to date in the area of standardization appear modest but positive. Specifically, this includes on-going work in the following areas:

- o Statistical compilation of over 50,000 patient diagnoses completed by expatriates working inside Afghanistan;
- o Development of standard diagnoses, using data generated from the above analysis;
- o Development of a therapeutic field manual (in progress) for use in Afghanistan by graduates of the many different PVO projects;
- o Simplification and standardization of medicines which are provided by the PVOs to their trained health workers inside Afghanistan; and

- o The plan to send into Afghanistan in the near future two monitoring teams, each composed of both a non-American expatriate and two Afghans, in order to provide independent verification and assessment of CMC member-group activities.

In many areas there remains a significant need to work together, however. This includes working towards a standardization of salaries for doctors, nurses, and other health staff and support workers financed by contractors and grantees; and the development of common terminology and definitions for health workers and facilities. The project should work closely with CMC in these important areas in the future.

During the last year PVO willingness to cooperate and share information in the forum of the CMC has increased in some regards, and this should be fostered. In addition, it is expected that as many as 10 to 12 additional health-related PVOs may begin to work cross-border as the refugees they are helping begin to move back to Afghanistan. It is likely that these organizations will also join CMC and, in fact, some have been invited to attend periodic meetings of the group and they have done so already.

The CMC has undergone changes in staffing recently, and the Medical Director has only been working in this capacity for the past month. A new Administrative Director is expected to be hired soon.

4.7.2 Conclusions/Lessons Learned

The project has worked both informally and formally with a number of PVOs who are also providing training and health services. It has gradually expanded its dialogue with CMC members, and has cooperated on specific activities of mutual interest. It is now becoming a full member of the forum.

A more recently formed coordinating body in Peshawar is ACBAR (Agency Coordinating Body for Afghan Relief), which is comprised of more than 40 comparatively small organizations from a number of different countries which are presently working with Afghans--both in the refugee population and cross-border. Established since the Geneva Accords, ACBAR serves as a general coordinating forum for a variety of organizations working in areas such as health, education, and agriculture.

It is envisioned that CMC might become the Medical Subcommittee of ACBAR, while CC (Cooperative Committee of Non-Health Cross-border Groups) and VAG (Voluntary Agencies Group of Refugee-Assisting Organizations) will assume other roles. This is indefinite as of yet, however.

ACBAR will in turn coordinate with the newly appointed UN Relief Coordinator for Afghanistan, Prince Sadruddin Aga Khan, whose representative is now in Pakistan to establish offices in Islamabad, Peshawar, and Quetta.

As far as United Nations organizations are concerned, the project is already cooperating with UNICEF in the area of immunizations. UNICEF is providing necessary drugs and supplies in a series of pilot activities.

From the above discussion it is clear that the project is part of a complicated array of agencies, all of which are intent on participating in one way or another in future developments concerning Afghanistan. In this setting cooperation is crucial.

In sum, experience to date has pointed up the importance of close cooperation among donors, be they bilateral, PVOs, or international. Thus far there has been a fairly clear cut division of tasks between those organizations doing cross-border work (e.g., this project, Swedish Committee, PVOs) and those supplying help to refugees (e.g., State Department programs, UNHCR, PVOs) in Pakistan. When the refugees start back in large numbers (probably in the Spring of 1989), organizations operating in Pakistan plan to begin cross-border assistance. This will enhance the need for close cooperation in order to avoid duplication, assure programs are complimentary, and apply common medical protocols, and standards. One of the lessons learned thus far is that achieving this cooperation is not easy because of the diverse interests and backgrounds of the myriad organizations working in the health field. Therefore, any continuing activity will have to stress this aspect. As of mid July 1988, the UN had not established meaningful coordination in the health field, and the representative of the UN Coordinator in Afghanistan (Prince Sadruddin) was not yet in place in Pakistan.

4.7.3 Recommendations

1. MSH, as an official member of CMC, should continue to participate fully in its activities with a view to helping it become more effective.
2. MSH should consider encouraging the CMC to play a more active role in coordinating specific activities of joint interest (e.g., setting mutually agreed salaries for the principal categories of health care professionals and support workers; establishing common data bases for management information concerning health personnel, clinics, and hospitals; sharing information on training, core curriculum, testing, evaluation and monitoring, implementation success and problems, data analysis, and so forth).

3. The project should make every effort to coordinate with international UN bodies concerned with the complex process of Afghan RRD as they become more established in the future.

5.0 FINANCIAL CONSIDERATIONS

5.1 Context (Findings)

To date, project expenditures, as noted on the next page in Table 3, have lagged behind program performance substantially. This has been due to the nature of the program and time phasing of specific project activities. The decision to proceed with training of Basic Health Workers (BHW) meant that curriculum, training facilities and recruitment were the first major sub-activities. Initially, this type of action does not result in major expenditures, although there are then major implications for future expenditures. In addition, the process of careful selection of appropriate medicine and medical supplies as well as the initial procurement difficulties described in Section 4.3 above, meant that major expenditures for commodities (the largest project cost element) have not taken place until recent months. As BHWs are trained and move inside Afghanistan, as clinics and hospitals are staffed inside Afghanistan and supported with supplies and equipment, and salaries and expenses for them paid up to six months in advance, expenditures will begin to rise exponentially--reflecting additional new units and personnel added to necessary resupply and further salary and expense payments. Also, the decision to pay all BHWs, which was made after the original funding estimates were calculated, has resulted in additional project expenditures.

The focus of project financing should now be concentrated on the future cost of current and proposed activities and their time phased funding implications. The emphasis on the lowest levels of the health pyramid to date (BHWs and clinics) is cost effective, since major expenditures for sophisticated hospital equipment and construction are not involved. This approach is managerially difficult and while the pace of expansion needs to be rapid in view of vast needs, careful monitoring of progress must be maintained. In view of current funding limitations, prudent management requires constant vigilance over program commitments which will lead to future expenditures.

To date, at the direction of the AID/Representative, MSH has followed a policy of "aggressive implementation." This approach has reached a point where more solid assurance of the availability of sufficient funds is essential to cover commitments being entered into right now. MSH has been following the spirit of the AID/Representative's instructions despite the risk to MSH of possible future liability or project disruption. Specifically, MSH is operating currently on the basis of a \$20.7 program for FY 87-89 versus the original \$10.6 program.

Table 3

Availability of Health Sector Support Project Program Funds
(FY 87 - 88)
(in millions of dollars)

<u>FY</u>	<u>Available</u>	<u>Accrued Exp.</u>	<u>Remaining</u>
87	9.9	2.1	7.8
88 (est.)	7.8	6.2	1.6

MSH has made a major effort to develop realistic time phased project budget estimates. This combines Lotus 123 and Dbase programs with periodic substantive input from experienced program managers. Even with the predictive difficulties inherent in the process (which are exacerbated by the fluidity of the current Afghan situation), this approach provides a framework for keeping on top of the implication of program changes and costs associated with additional or modified activities.

5.2 Conclusions/Lessons Learned

MSH has shown admirable willingness to comply with the AID/Representative's wish for "aggressive implementation." For the benefit of all concerned, AID/Rep's direction and instructions to proceed full speed ahead need to be reflected in the AAM Amendment and follow-up action taken as soon as possible. While the team agrees with the AID/Rep's intent and MSH's action, prudent management calls for "risk management, i.e., risk minimization." To avoid a potential rupture in supplies and operations, additional funds are required by the first quarter of FY 89 at the latest and preferably during the last quarter of FY 88, if at all possible.

In a situation where there is a need for rapid program implementation to meet clear requirements, prudent management calls for very careful monitoring of program commitments which will tie up the funds available. This is in addition to the valid concern about the rate of accrued expenditures.

5.3 Recommendations

1. That current instructions to MSH for "aggressive implementation" be reflected in the AAM Amendment with follow-up action as soon as possible.
2. For program management purposes, current and future funding availability should be made as concrete as possible even in the face of the difficulties in doing so.
3. That on the basis of current information, additional funding be made available as soon as possible (no later than the first quarter of FY 89) to avoid potential delay and postponement of procurement and other essential project activities.

SCOPE OF WORKArticle I - Title

Macroeconomic Analysis Services, Health Sector Support Project, Afghanistan Assessment and Design

Article II - Purpose and BackgroundA. Purpose

- I. Examine needs in the health sector and their related macro-economic and fiscal impact;
- II. Assess the effectiveness of the project in light of the original Activity Identification Memorandum (AIM), Activity Approval Memorandum (AAM) and annual work plans; and
- III. Revise the AAM to better reflect present and future requirements in the health sector.

The AAM amendment should address not only the economic/financial, technical and administrative problems emanating from the assessment, but should also reflect the broad policies and direction A.I.D. should take in regard to health care needs for Afghanistan in the evolving political and economic situation we seem to be facing. At a minimum, the amendment should build in the implementation flexibility to the existing authorization to allow the AID/Rep to respond adequately to rapidly changing political and economic conditions. The team will have to determine what should and can be done in the health sector, for how long, and at what economic and financial cost.

B. Background

The AAM for the health sector support project (306-0203) was approved by the AA/ANE in late FY 86. The AAM (relying heavily on the AIM for its analysis) consisted of various implementation option/arrangements. The project was designed to establish and expand health services inside Afghanistan as rapidly as possible and strengthen the capability of the Alliance Health Committee (AHC) of the Seven Party Alliance to plan, operate and monitor these services. Initially, the project operated according to the immediate needs in the health sector rather than a fixed plan. While it was necessary in the beginning to retain this flexibility to respond to urgent requests, we also saw the need for more definition and direction to health care delivery. Thus, within six months of authorization the TA Team developed relatively detailed

annual work plans in cooperation and consultation with the AHC. These annual work plans now serve as the blueprint for implementation and the basis by which problems are identified and progress is measured.

The project now focuses its efforts in four general areas--medical training, finance and administration, medical services, and procurement and supply. The Training Division has graduated over 300 Basic Health Workers (BHW) and established a Training Center which is responsible for training BHW teaching staff, developing refresher training for physicians and nurses and producing materials and texts. The Finance and Administration Division has established systems to manage the fiscal resources given to the AHC system. This includes financial operations for payment of salaries as well as costs for transportation supplies into Afghanistan. The Medical Services Division is actively coordinating with the parties in the development of new facilities inside Afghanistan and implementing a Three-Tier Monitoring and Evaluation System. The Procurement and Supply Division has organized the movement of supplies from the Peshawar warehouse up to the border and inside Afghanistan.

The Alliance Health Committee has correspondingly increased their administrative staff in each of these divisions. It should be noted, however, that only four of the seven parties of the alliance are active participants in the health project. The other three could join soon. The Senior Members of the AHC have formed a High Council which provides oversight and policy direction to the Technical Divisions. The president of the AHC and the High Council rotate every four months.

The project was authorized with a LOP of \$16.6 million for a three year period ending on August 8, 1989. The cooperative agreement with Management Sciences for Health was signed in the amount of \$15.7 million. The original program budget (\$10.6 million excluding contractor costs) was based on a series of outputs that were the minimum required to have an impact on health and emergency care in Afghanistan. Approximately 18 months of implementation has demonstrated that many of the original cost estimates were erroneous. Based on present figures, program costs would have to be doubled to sustain original outputs.

If we stay with the original outputs, the LOP authorization will have to be amended. The team will need to review the original outputs, rank them in light of economic and financial constraints, and recommend any revisions and additions to these. While this is a very important issue, we are aware of other equally important areas that need to be addressed. These issues will be the basis for the assessment and redesign.

Article III - Statement of Work

A. Assessment

The team will be responsible for studying the relevant data on health conditions inside Afghanistan, assessing the overall appropriateness of A.I.D. assistance and recommending specific improvements which can reasonably be implemented in light of the current and evolving economic, political and institutional environment. This will include (but is not limited to):

1. Review mechanisms used to finance and manage the AHC and recommend alternatives.
2. Review the monitoring, evaluation and accountability efforts of the Health Sector Project.
3. Prepare for AID/Rep a review draft memorandum covering the findings and conclusions of the evaluation and assessment phase. This memorandum serves as a basis for the first portion of the revised AAM, including the background and assessment of current program sections.
4. Review and determine the level, adequacy and effectiveness of the technical assistance team. Are there sufficient numbers with appropriate background to meet objectives?
5. Review the epidemiology of disease and population demographics (including distribution) inside Afghanistan.
6. Review what is presently provided in the health project and by PVOs--including, but not limited to, type of training, output and level of health personnel, geographic location, number and level of health facilities, type and amount of commodities (equipment, drugs and medical supplies).
7. Review/determine the relative importance of various types of programs--casualty/emergency care, primary health care, immunization, public education, etc.
8. Determine whether present outputs and type of health care workers is appropriate, e.g., BHWS, medics, physicians/nurses.
9. Review input aspects of commodity procurement, storage, and repacking implemented by MSH and AMEG; determine whether procedures/resources are adequate.

B. Design

Before departure, the team will prepare a draft of a revised AAM which incorporates their findings and recommendations derived from their review of the present project and other programs financed by A.I.D. More importantly, the revised AAM will address the direction/expansion of the Health Sector Project in a post-war scenario. This extension will have to take into account potential changing relationships with the GOP, AHC, Alliance, PVOs, and Afghanistan projected economic and financial constraints. There are not now nor will there be easy answers for this. What we do know is that the needs will be great. It will be up to the team to provide the broad parameters in which we can work. The team will be responsible for addressing the following in the revised AAM:

- Various funding scenarios based upon what the team feels is indicated to address current and future health needs (upper limits are appropriate for existing and potential circumstances).
- A new life of project and PACD.
- A review of existing waivers and the incorporation of any new ones necessary to execute the amended AAM.
- A broad policy discussion which would provide (upon AID/W approval) the AID/Representative authority to maintain, alter, or expand the project in response to quickly changing economic and political circumstances.

Determine objective, content, and delivery mechanisms for activities to be conducted under the project extension.

C. Methods and Procedures

The assignment will be carried out under the day-to-day guidance of the AID/Rep, Larry Crandall, and his staff in Islamabad and Peshawar.

The assignment will be accomplished by:

I. Document Review

Review of country and project documents especially AIM, AAM, annual work plans, quarterly reports, and previous evaluations.

II. Team Planning Meeting

Holding a Team Planning Meeting in Washington, D.C. prior to departure for Pakistan. TPM will be organized along the WASH project guidelines. The TPM will produce a report format (Table of Contents), a work plan, and a delegation of work assignments among the team members.

III. Evaluation and Assessment

The team will spend weeks one to three in the field carrying out the evaluation of the Health Sector Support Project (303-0203) and the health sector assessment of Afghanistan. The team will review relevant data, interview project staff and beneficiaries, make site visits, interview PVOs, interview AHC and meet with AID/Rep staff. A briefing for the AID/Rep staff will take place when Phase III is complete.

The team will prepare for AID/Rep's review a draft memorandum covering the findings and conclusions of the evaluation and assessment phase. This memorandum will serve as a basis for the first portion of the revised AAM, including the background and assessment of current program sections.

IV. Redesign

Based upon the findings and conclusions reached from the evaluation and assessment, the team will develop:

- Recommendations for AAM amendment;
- Recommendations for the direction/expansion of the health sector project in a post war scenario taking into account the potential changing relationships with the GOP, AHC, Alliance, PVO, beneficiaries, and GOA; and
- Recommendations for broad parameters for a post-war A.I.D. health program strategy.

The above will be completed during the fourth and fifth weeks of the assignment.

A briefing for the AID/Rep staff will take place when Phase IV is complete.

Article IV - Reports

A. Draft Report:

During the last week the team will prepare a draft report including:

- Findings and conclusions of the evaluation and assessment;
- Recommendations for the health project and post war health strategy; and
- A revised AAM (see C II above).

Debriefings for AID/Rep, AHC, MSH, Embassy, and other interested parties will be arranged during this final week.

B. Final Report

A revised AAM will be the sole output of this assignment.

- a. Table of Contents
- b. Map(s)
- c. Acronyms
- d. Executive Summary
- e. Project Data Sheet
- f. Body of Report (including summary of findings, conclusions, and recommendations, not to exceed 40 pages)
- g. Appendices (scope of work, logical framework, description of methodology, bibliography, list of contacts)

The revised AAM will include findings, conclusions, and recommendations developed during Phases III and IV of the scope of work.

The team will have thirteen workdays in the U.S. for integrating comments and corrections and preparing the final report. The Team Leader will submit ten copies of the final report to: Kristin Loken, Agency for International Development, Room 4720, N.S., ANE/TR/HPN, Washington, D.C. 20523.

Article V - Technical Directions

Technical directions during the performance of this delivery order will be provided by the A.I.D. Project Officer pursuant to Section F.3 of Contract No. PDC-0000-I-00-6134-00.

Article VI - Term of Performance

- A. The effective date of this delivery order is May 2, 1988 and the estimated completion date is August 25, 1988.

METHODOLOGY

Members of the Health Sector Support Assessment team spent from June 4 to July 9, 1988 in Islamabad and Peshawar assessing the on-going implementation of the project in light of the purpose and tasks assigned the Management Sciences for Health (MSH) team in the Cooperative Agreement listed in Section 2.0 below. The Activity Identification Memorandum (AIM) and the AAM served as foundation and background documents for the team allowing them to put the activities under the Cooperative Agreement in proper perspective. The team utilized the year one and two work plans to focus on more specific goals and targets, and assess the progress to date.

The composition of the assessment team was as follows:

Vincent Brown	Team Leader/Development Economist
Pamela Hunte, Ph.D.	Social Scientist/Ethnographer
Kristin Loken	Health Specialist
Charles Stockman	Senior Finance Specialist

In carrying out their mandate the team members began with a team preparatory meeting (TPM) in Washington for two days in early May, and was briefed by appropriate members of AID/W and State Department Staff, and by the AID Representative for Afghanistan, Larry Crandall who was in Washington on TDY. A tentative work plan was established as a result of these briefings, and key documentation (AIM, AAM, Quarterly Reports, Work Plans, etc.) were supplied to the team for study.

On arrival in Islamabad, team members were briefed by the Project Officer, Dr. Carole Scherrer-Palma, Acting AID Representative, Jack Miller, and other members of the AID Representative for Afghanistan staff. Article III of the Scope of Work was reviewed with the team and clarified by the Project Officer pointing out that the team did not need to review mechanisms used to finance and manage PVOs nor comment on the Medical Evacuation program. Courtesy calls were made on the UNICEF Representative, Carl Schonmyer, and UNHCR Senior Health Coordinator, Dr. Richard Nesbit.

The team's main base of operations was Peshawar in the North West Frontier Province (NWFP) where the MSH team and Afghan Alliance Health Committee (AHC) is based, as well as the AHC training facilities and PVOs carrying out training and supporting the health sector in Afghanistan. (AID's projects in Education, Commodities and Agriculture are also located in Peshawar.)

Extensive discussions were held with Dr. William Oldham and the members of his MSH staff regarding the Health Sector Support Project and its work with the AHC, its training center and four training units for basic health workers (BHWs) in the mujahideen

camps of the four Alliance parties participating in the program. (While the team was in Peshawar one additional political party, tanzeem, of the Alliance announced their intention to join the MSH/AHC program bringing the total to 5 out of 7 Alliance members participating in the Health Sector Support program.)

In addition to studying the latest MSH reports and documentation, the team had an opportunity to visit the training camps and to meet with the Chairman of the AHC, individual members of the AHC Medical Sub-committee, the Director of the AHC Training Center, representatives of the PVOs working in the health field, and the Government of Pakistan liaison officer based in Peshawar.

To sum up, the team is very grateful for all the help it received in preparing this assessment. Its conclusions are based on study of existing documentation, in-depth conversations with USAID, the MSH team, other contractors/grantees (PVOs), members of the Alliance Health Committee and staff, Afghan doctors, health workers, and other individuals working in the field.

The team has benefited greatly from the counsel and advice of those working on implementation on a daily basis in Peshawar, Islamabad, and inside Afghanistan, and many of the conclusions and suggestions expressed in the report are based on these conversations. However, the assessment team accepts full responsibility for its conclusions, prognostications and recommendations.

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2. JABHA- <u>NAJAT-I-MILLI</u> AFGHANISTAN (National Liberation Front)	PROF. SEBHATULLAH <u>MUJADIDI</u>
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4. <u>HEZB-I-ISLAMI</u>	MAWLAWI MOHAMMAD <u>YONUS KHALIS</u>
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 The popular party name is underlined here; in this report leader's names are used with reference to the parties.