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AN UPDATE
AND
RECOMMENDED IMPLEMENTATION ARRANGEMENTS
FOR AID CROSS BORDER HEALTH ASSISTANCE
ACTIVITIES TO IMPROVE THE HEALTH OF
WAR-AFFECTED AFGHANS

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I. EXECUTIVE SUMMARY

The people of Afghanistan have suffered terribly since the 1978 "Revolution" with over one-half million dead, four million refugees, and over one and one-half internal refugees--displaced from their homes. The US Government, through AID, has begun humanitarian efforts to help these courageous people, including a cross-border assistance program in health. In November and December of 1985, a health planning team began the planning efforts and wrote a document entitled Recommended AID Cross Border Humanitarian Assistance Activities to Improve the Health of War-Affected Afghans. This document, also serving as an interim health sector strategy, resulted in AID approval of an Activity Identification Memorandum (AIM) endorsing the elements of the proposed health sector activities but asking the USAID Office of Afghan Affairs to complete the planning process and submit another document for final approval. This report is that document and is submitted for approval as an Activity Approval Memorandum (AAM).

The proposed health activity's purposes have not changed nor has its strategy to achieve those purposes. Simply stated, these are to expand health services inside Afghanistan as rapidly as possible and strengthen the capability of the health committees of the Seven Party Alliance to plan, operate, and monitor expanded health services in Afghanistan. The strategy is to carry out a massive training effort to "fill up" the nearly empty health system with trained workers who can care for war injuries and the civilian population, and to make available the necessary drugs, medical equipment, and medical supplies to support an expanded health care system inside Afghanistan.

During the four months between the health planning team's visits, the war had intensified, especially in the border areas, and casualties were high among civilians and mujahiddin. In Pakistan, the change from Martial Law to a civilian government and the planning for the UN-sponsored Geneva VII proximity talks had dominated the attention of those GOP officials concerned with Afghan affairs. In the health sector, the AID-funded PVOs had started their training programs. They had established a coordinating body called the CMC (Coordination of Medical Committees) to share training experiences, to develop standard drug lists, and coordinate, to a limited degree, with the party health committees. The seven party health committees had made little, if any, progress due to lack of funds and lack of organizational capacity. AID staffing had improved considerably and the USAID Mission was able to function much more effectively.

Many issues have been clarified since the previous report. It is now clear that medical equipment through Department of Defense excess property should be viewed as supplementary to the expected needs, rather than forming a basis on which to plan. It is now likely that the McCollum Amendment which offers transportation support will likely be available on a multi-year basis and should be able to finance most of the transportation costs to Pakistan, within Pakistan, and inside Afghanistan.

At the beginning of the health planning team's second visit, the Afghans were somewhat dubious about AID's potential contribution. Six months had elapsed and AID was still in the planning stage! Even though the delays were explainable, the party health committees voiced disappointment, particularly since AID was funding PVOs but not them. Over the five week visit, considerable progress was made in organizational development of the Alliance Health Committee and in improving the coordinating mechanisms between the PVOs and the Alliance Health Committee. The Alliance developed several policy measures related to AID assistance in health, both for itself and for PVO coordination. They developed an initial plan for a cross-border health program management unit, to be called the Alliance Secretariat, which included various departments to carry out the cross-border program. Serious discussions were held about how AID might disburse funds and how a technical assistance team would relate to the Secretariat and the Alliance Health Committee. At the end of the visit, the Afghans again have high expectations of creating an Alliance-led health services system in Free Afghanistan.

The visit clarified the roles and coordination mechanisms of the various implementing institutions. The Alliance will, over time, be responsible for operating the health services inside Afghanistan through the management mechanism of the Alliance Secretariat, (subject to adequate AID funding). Most PVOs will coordinate with the Alliance in the nomination and selection of trainees and, to the extent required, in other areas until the Secretariat is functioning adequately. The technical assistance team will help both the Alliance and the PVOs. The Government of Pakistan's views are not yet clear. AID will monitor PVOs and the technical assistance team directly, and will expect the technical assistance team to help them monitor the activities of the Alliance. The health project will retain its own project medical supply service and plans to rely on the Commodity Export Program to assist with movement of goods from the US to Pakistan. The implementation schedule is similar to the MSH Reference Report and cannot be improved until the amount of funding is known.

Five options for the financial administration of AID funds were analyzed and one is clearly preferable. At the beginning of the development of the Alliance Secretariat, it is preferable for an intermediary organization with strong financial planning and management skills to manage and disburse funds to the Alliance on AID's behalf. The intermediary organization will maintain tight financial control in the earliest stages and pass financial control to the Secretariat based on their ability to use and account for AID funds satisfactorily. This same organization will provide technical assistance in training, supply management, health operations, and organizational development of the Secretariat.

The proposed program was developed with the Alliance and is endorsed by the Alliance Health Committee. The Afghans are eager to proceed and need help fast--the war continues every day and the pressure on the Afghan people is constant, brutal, and creates great suffering. It is important that AID not lose credibility by delays in approval or by approving marginal amounts of funds.

II. INTRODUCTION

A. OBJECTIVES OF THIS REPORT

The overall objective of this report and its Annex is to be an Activity Approval Memorandum (AAM) for the Afghanistan Health Activity (306-0203). This report is based on the MSH document entitled Recommended AID Cross Border Humanitarian Assistance Activities to Improve the Health of War-Affected Afghans, dated January 10, 1986, and incorporates this report by reference. In late January, 1986, the AID Assistant Administrator for the Asia and Near East Bureau, through the mechanism of the Asia and Near East Project Advisory Committee (ANPAC), reviewed the MSH report and agreed to approve it as an Activity Identification Memorandum (AIM). The ANPAC requested the AID Representative for Afghanistan Affairs to develop an AAM for AID/W approval based on the MSH report "with emphasis on rapid impact elements" and taking into account the guidance described below.

Guidance from the ANPAC

Budget: It is unlikely that all the funds requested for health activity will be available. Several relevant factors have not yet determined such as extent to which DOD may be able to provide commodities or cover transportation costs and the extent to which Section 451 funds may be used for PVO grants. As such, the AID Rep should determine allocations for the total Afghan program and advise AID/W of the FY 86 obligation amounts. A minimum budget for high priority items should be determined for all sectors. This would provide flexibility for adding activities as funding levels allow. In health, the project elements are approved but AID/W requests that AAM indicate which elements at what funding level can be accommodated within anticipated budget availabilities and what information and evaluation criteria will be available to determine whether or not the project should be expanded at some point in the future.

Implementation Arrangements: The AAM should describe the administrative and institutional arrangements through which implementation will occur, including the roles of the health committees of the Seven Party Alliance, GOP/PWI roles, coordination with PVOs operating in the health sector, and how a technical assistance team would operate.

Salary Support: The ANPAC agrees that salary support and family support are appropriate and necessary elements to enable workers to return to or remain in Afghanistan and requests that every effort should be made to keep these long-term recurrent costs to minimum essential levels.

Technical Assistance Team: The ANPAC discussed security concerns associated with posting additional Americans in the area, but concludes that the project cannot be implemented without technical assistance.

The specific objectives of this report are to provide a brief review of the MSH Reference Report, an update of the recent developments in Afghanistan and Pakistan affecting the proposed health activity, and to address the relevant topics in the ANPAC guidance described above.

B. BRIEF REVIEW OF MSH REFERENCE REPORT

The people of Afghanistan have suffered terribly since the 1978 "Revolution" with over one-half million dead, four million refugees, and over one and one-half million internal refugees--displaced from their homes. Since 1979, a spontaneous resistance to the Karmal regime and the Soviet invasion has developed, with many trials and tribulations, into a fragile alliance of seven parties linked somewhat loosely to many military commanders inside the country. Of the approximately 12 million people living in Afghanistan, about 9 1/2 million live in "free" areas, but Soviet tactics are exacting a heavy price and emigration to Pakistan and to Kabul are increasing. Deaths attributed to the war have raised the death rates by 58-105%; illness problems are similar to before the war--only worse--and epidemics of measles and other diseases particularly take their toll on the displaced persons. In militarily active areas, civilian casualties are thought to be 3-4 times mujahiddin casualties.

Both parties and a number of PVOs are trying to provide services inside Afghanistan but the numbers are low relative to the need. The parties have limited funds and the refugees claim a great deal of their time and resources. Given the lack of funds and the lack of administrative experience, the party health committees are not very well organized, although there is

a great amount of variability. A number of organizations have been training "first aiders" and a few are beginning to train nurses for war-related health work. Drugs and medical supplies are available through some foreign organizations and are not in such short supply if their usage is matched with the number of trained workers inside the country. However, as the workers increase, many more drugs will be needed. Medical equipment is in short supply.

The health activities will follow a number of strategic principles to gain and maintain the confidence of the Afghan parties and to help minimize the "push" factors that the Soviets and Karmal government are using to drive the population into Pakistan or into government-controlled areas. These include respect for the values of the Jihad; concern about food and shelter, as well as health; the importance of meeting the health needs of civilians as well as fighters; and the need for flexibility, recognizing that the Soviets and Karmal government will try to develop countervailing strategies. The program itself has three objectives--to expand and improve (1) medical and surgical care for war casualties; (2) general health care for civilians as well as mujahiddin; and (3) the capability of the Health Committees 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 Surgical Hospitals, and larger, semi-permanent Combat Surgical 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. Portions of AID assistance, including some transportation costs, will be supplemented from funds available through the McCollum amendment.

C. THE ROLE OF THE REFERENCE REPORT AS A HEALTH SECTOR STRATEGY

Conventional AID practices dictate that policy guidance is decided in Washington but that the field missions develop the strategies to implement the policies. The overall strategic plan is written as a Country Development Strategy Statement (CDSS) with a strategy for each sector in which the mission plans to have a program. Due to the circumstances in which the Office of Afghan Affairs operates, a broad overview report by Mr. Larry Crandall functioned as a CDSS and then the actual programming cycle began. As such, a detailed health sector analysis and strategy did not exist when the MSH Reference Report was written.

The MSH Reference Report was written to function both as an interim health sector strategy and as a programming document. As such, it is meant to provide guidance for all health sector activities of the USAID Office of Afghan Affairs. Its goal, purposes, outputs, and implementation strategies are meant to include potential activities of both the Alliance and the Private Voluntary Organizations. Section III of this report will update that reference report with particular guidance on the desired role of PVOs in the overall health sector program.

D. RELEVANT DEVELOPMENTS IN AFGHANISTAN AND PAKISTAN DURING JANUARY-APRIL 1986

Since the health team's departure from Pakistan in late December, 1985 to its return about May 1, 1986, a number of relevant developments had occurred in Afghanistan and Pakistan. In Afghanistan, the war had intensified since early Spring and the Soviets and DRA strategy had been to reduce mujahiddin access inside Afghanistan by sealing off the border areas. There were several important battles, heavy bombing, efforts to set border tribes against each other, and reports of crop and village destruction. As might be expected, there were heavy casualties among both mujahiddin and civilians and, in many areas, food supplies for this upcoming winter are expected to be in short supply. Unfortunately, the Soviets and DRA were relatively successful--the movement of mujahiddin, supplies, and equipment has been diminished and the costs of transport has increased. On the Pakistan political front, the change from a Martial Law to a civilian government and planning for the UN-sponsored Geneva VII proximity talks had dominated the attention of those GOP officials concerned with Afghan affairs

and slowed down GOP approvals for the final humanitarian assistance design activities. The GOP had also apparently changed its policy toward the use of Pakistan Welfare International (PWI) as a lead organization for humanitarian assistance to Afghans.

In the health sector, most PVOs began to train their first classes and were preparing to place their graduates inside Afghanistan. As such, they were extremely busy. Some PVOs tended to operate rather independently while other PVOs had established training linkages and were training each others students in selected subjects. In general, PVO collaboration had been on the increase and the PVOs had formed a body called the Coordination of Medical Committees (CMC) for coordination purposes. The overall goals, policies, and procedures of the CMC were still under discussion but actions had included sharing of training experiences, development of a standard list of drugs and treatment protocols, and coordination, to a limited extent, with the party health committees. The CMC-party health committee meetings had variable attendance by party representatives and, at times, by PVO representatives. These meetings did raise a number of issues where there was a wide difference of opinion among the two groups.

At the time of the team's arrival on May 1, most of the PVOs had only limited linkages with the health committees of the political parties in selection of trainees, usually preferring to establish their linkages for student selection and deployment directly with military commanders responsible for various field areas inside Afghanistan. They had gained more experience at training and most planned to operate their own health services inside Afghanistan. Some PVOs were cooperating with each other in planning their health services inside Afghanistan while others were working by themselves with selected commanders. The PVOs had minimal, if any, service planning linkages with the party health committees.

In December, 1985, while the health team was in Peshawar, the leader of the Seven Party Alliance announced the formation of a Seven Party Alliance Health Committee. The members of that committee had met with the health team prior to the team's departure. As of the arrival of the health team around May 1, 1986, the Alliance Health Committee (AHC) had not yet again met except when requested by the CMC. More disappointingly, the Ibn-e-Senna Hospital, previously operated by three of the parties, had been under dispute and was only being operated by one of the parties--the other two being without facilities. The parties themselves had made little progress in health. As noted

in the previous MSH report, the capability and health activities of the individual parties inside Afghanistan vary widely. Only two or three of the seven parties have clinics and a few small hospitals in operation inside Afghanistan. During these last four months, two of the party health committees (Sayyaf and Hezb-i-Islami-Gulbaddin) had training programs underway. However, it is unlikely that any expansion in services has actually occurred. The parties were still hampered by shortages of funds, lack of trained health care providers, lack of managerial and logistics skills, and heavy responsibilities for Afghans living in Pakistan.

It is important to note the important changes in AID capability during this time period. In December of 1985, the AID Representative received his first permanent professional staff member. In March, the health sector was assigned to a newly arrived staff member. By May 1, there were four direct hire staff in Islamabad plus a representative in Peshawar. This enhanced capability is very important in the health sector as a number of areas required AID attention.

E. STATUS OF COMMODITY SUPPORT THROUGH DOD EXCESS PROPERTY AND TRANSPORTATION SUPPORT THROUGH THE MCCOLLUM AMENDMENT

At the time the previous report was written, it was not clear whether DOD excess property or transportation funds through the McCollum Amendment would substantially reduce the costs to AID for medical equipment and for transportation. In February, following a series of discussions with the Office of Humanitarian Assistance at the Department of Defense, it became clear that DOD excess property would not repeat not likely be available in the quantities required nor in a timely fashion to meet the vastly expanded needs envisioned by the health activities. In fact, medical equipment from DOD excess property should be viewed as supplementary to the expected needs. As a result, AID should plan to purchase such equipment with AID funds and so indicate in the budget.

While the situation vis-a-vis DOD excess property was financially disappointing, the situation vis-a-vis the McCollum Amendment is quite positive. At the present time, it appears likely that McCollum funds will be made available on a multi-year basis and significant portions of those funds will be made available to the AID Office of Afghan Affairs for use in financing transportation costs in Pakistan and inside Afghanistan. As such, the AID-financed budget for transportation costs for the health sector will be substantially reduced.

F. RESULTS OF THE HEALTH TEAM'S VISIT

This subsection summarizes the activities and results of the health planning team's five week visit to Pakistan. Details of the meetings are found in the Annex.

Within the first two days of arrival in Peshawar, the health team attended two meetings--one with the CMC and one where the CMC and party health committee members met together. It was clear that there were strong differences of opinion between the groups regarding responsibility for planning, organizing, training personnel, and delivering health services inside Free Afghanistan. The PVOs were proceeding with their plans of action essentially as before the establishment of the AHC in December--with varying coordination among themselves and minimal coordination with the parties or the Alliance Health Committee. Since the AHC hadn't been meeting before the health team arrived (except when called by the CMC), the PVOs felt that their position was both practical and reasonable and, in addition, suited their preferences on the whole. They clearly wanted to operate independently of the parties in training as well as in planning and implementing health services inside Afghanistan. They perceived their best coordination link to be with commanders--only if necessary did they want coordination with parties or an AHC. Their position at the beginning of the health planning team's visit might be summarized as follows.

General Views of the PVOs

- The party health committees are not organized.
- When the PVOs have attempted to clear potential students through the parties, the parties have failed to follow-up and do their part.
- The Alliance is politically motivated and unable to agree on organizational issues.
- The Alliance cannot be trusted to deliver goods and services inside Afghanistan, rather they are mainly concerned with Peshawar-based health services.
- External resources would mostly be diverted into Pakistan for refugee programs or private practice.
- Selection of trainees will be on political and family grounds rather than on merit or willingness to work inside Afghanistan.

-The party members don't come to coordination meetings on a regular basis.

The Alliance Health Committee expressed a different position centering around the issue of "control." Their initial position may be summarized as follows:

General Views of the Alliance Health Committee

-The AHC should have responsibility for coordinating and approving all cross-border health activities.

-The AHC should control PVO health activities and all AID funds in health.

-The AHC felt that the PVOs were "out of control" and this was harmful to the resistance movement; that they posed security problems; and that it is inappropriate for foreigners to operate their own programs inside Afghanistan.

-The AHC was disappointed to find out that some PVOs were receiving AID funds while the Alliance was not yet receiving any AID funds. They wondered about AID's motives.

-The AHC felt that if they had funds for staffing and for training, they could do the job that the PVOs had begun--better and at lower cost!

The health planning team began a process of meeting alternatively with the AHC and the CMC. The AHC was refreshed on the previous MSH report, briefed on the AID/W meetings, learned more clearly why there had been delays in the follow-up visit, and were reassured that AID was still interested in an Alliance Health Program and was prepared to act promptly to get final approval. The AHC was asked to give its views on how best to proceed with cross-border health sector activities and they produced "Eight Principles" on which further discussion should be based. The MSH team, with the concurrence of the AHC, then presented the "Eight Principles" to the PVOs in a CMC meeting, briefed them on other pertinent impressions and presented the health planning team's views on the administrative arrangements. The CMC members commented on the "Eight Principles" and on the administrative and institutional arrangements under discussion. The revised "Eight Principles for AID Assistance in Health" are as follows:

Eight Principles of the AHC for AID Assistance in Health

1. The priority need is for the training of first aides and mid-level personnel.
2. The training programs for first aides and mid-level personnel should have a standardized curriculum, training materials, and manual.
3. The recruitment of persons for training will occur in accordance with the principles and policy of the Alliance Health Committee.
4. AID assistance in health should be exclusively given to the AHC for both training of personnel and provision of health services inside Afghanistan. The AHC should be the main implementing organization for cross-border programs. PVOs which implement health services inside Afghanistan must have the agreement of the AHC before carrying out such services.
5. Cash assistance should be paid to technical personnel (first aides, technicians, nurses, and doctors) when they are under training and conducting their duties in the homeland.
6. Employment of technical personnel inside Afghanistan should take place within the framework of the AHC and only after the approval of the AHC.
7. The appointment of technical personnel in Afghanistan (numbers and locations) will be by the AHC, following consultation with the military committee of the resistance parties within the Alliance, and is dependent on the needs of the mujahiddin and civilian population.
8. The AHC finds it necessary to establish housing and classroom space for students undergoing training in health courses.

Following this, another two meetings occurred with the AHC focusing on project administration (formation of an AHC Management Unit called the AHC Secretariat, staffing of the Secretariat, coordinating linkages with the CMC, how AID funds would be administered and disbursed, etc), and then a final wrap-up meeting with the CMC was held.

The results of these meetings plus a number of informal discussions with PVO members and some party health committee members, were as follows:

Final Views

PVOs

-Most PVOs are be willing to coordinate their efforts with the Alliance Health Committee when it is organized and has a program, although with some reservations and many anxieties.

-Most PVOs are willing, in principle, to work within the context of the "Eight Principles" with the exception of Principle 4 which requires further discussion. They feel strongly that many of the other principles need further clarification plus detailed implementation procedures and their agreement is subject to acceptable clarifications and procedures.

-PVOs view training as a major part of their activities but also are interested in operating health services inside Afghanistan themselves.

Alliance Health Committee

-The AHC endorsed the cross-border program and wants to be the responsible group to manage it.

-The AHC is willing to have support from PVOs who are willing to follow the "Eight Principles" enunciated by the AHC.

-The AHC accepted, in principle, the administrative and financial arrangements discussed in Section IV of this report.

In addition to the discussions with the CMC and the AHC as described above, the health planning team made a number of field visits and spent considerable time on adjusting the outputs and budgets to three possible funding scenarios: a minimum program, a moderate program, and a maximum program. The team also worked with USAID's program office on health sector ABS planning.

The most important impressions by the health planning team were the very positive attitudes of the AHC toward a coordinated Alliance-oriented, rather than party-oriented, approach. They also showed considerable maturity in their decision-making regarding the Alliance itself and about the Alliance-PVO relationship. The PVOs, while willing to coordinate, will not press the issue and expect the AHC to take a year or so to get organized and operational--even with technical assistance. The health planning team felt that considerable progress had been made on these coordination problems and that, once an Alliance Health Program started and both the AHC and the PVOs were busy, these problems would be solvable through the combined efforts of the technical assistance team and the USAID mission.

III. SELECTED UPDATE OF MSH REFERENCE REPORT ON THE ROLE OF PVO'S AND ON PROJECT OUTPUTS

Based on (1) the ANPAC guidance to focus on rapid impact elements in health and to accomodate the level of outputs to anticipated budget availabilities; (2) the relevant developments in Afghanistan and Pakistan during January-April 1986; (3) the clarification of commodity support through DOD and transportation support through the McCollum Amendment; and (4) the outcomes of the team's visit, it is worthwhile to update the MSH Reference Report on the role of PVO's and on the project outputs. However, while this update is important, it is crucial to note that the goal, the three objectives and the overall strategy are unchanged.

A. GUIDELINES FOR THE ROLE OF PVO'S IN THE OVERALL HEALTH PROGRAM

The first MSH Report described the purposes and outputs for all proposed health sector activities, but did not adequately address how PVO health activities should be carried out within the context of the overall AID cross-border humanitarian program in health. At that time, it was not clear if Pakistan Welfare International might be constituted or whether Section 451 grants would be separately administered by Washington. At the present time, it appears that PWI may not play an administrative role and that all USG funds available for cross-border programs will be in the AID ESF account under the overall guidance of the Asia Near East Bureau of AID and managed by the Office of Afghan Affairs.

AID is currently funding a number of PVOs who receive funds from other sources as well. Several are non-American organizations. At the present time, several additional PVOs are requesting support and the currently funded PVOs are requesting more funds for the coming years. The sum of these requests exceeds the presently available funds for the entire AID program, not just the health sector! For AID to make decisions about PVO health program funding, guidelines on the desired role of PVO's in the overall health program are useful.

In the MSH Reference Report, there were three purposes--all approved by AID/W. The first two are concerned with rapid expansion and improvement of health services to the people in Afghanistan and the third is concerned with strengthening the capability of the Health Committees of the Seven Party Alliance to plan and manage AID-assisted health activities inside the country. This second report reconfirms the importance of all three purposes but suggests that the first two--rapid expansion and improvement of health

services to mujahiddin and civilians--take precedence over the third purpose in the short run. If this assumption is accepted, it is possible to establish some overall guidelines for the role of PVO's in the overall health program that may assist decision-making from the technical and organizational points of view. The guidelines may be stated as follows.

Guidelines for the Role of PVO's in the Overall Health Program

1. In the short run (1-3 years), PVO's are necessary to meet the purposes of rapid expansion and improvement of services inside Afghanistan. As such, continued funding of PVOs whose programs support these purposes is important. The most important task to rapidly expand and improve health services inside Afghanistan is training of first aides and nurse/paramedics. Those PVOs with the current or potential capacity to rapidly expand their training efforts to help "fill up" the country with trained workers should be encouraged to do so and receive priority for funding among PVO applicants.
2. Since the critical role for PVOs in the short run is training, PVOs should focus their efforts on a rapid expansion of training, rather than on operating their own health services and programs inside Afghanistan. If and when they operate health services and programs inside Afghanistan, they should view these activities as extensions of their training efforts and use them to improve both their own training and the training and health services carried out by the Alliance. The Alliance should have the responsibility for operating health services and programs inside Afghanistan.
3. PVOs should be evaluated on the quality of their training programs in imparting standardized core skills to trainees, on the volume of their output, and on their cost per graduate by the type of worker trained. The PVOs should receive their drugs and supplies through the overall health project channels.
4. PVOs should be encouraged to support the third purpose of strengthening the capability of the Alliance by coordinating with the Alliance in the planning and operation of training programs and in resolving issues which are detrimental to the empowerment of the Alliance Health Committee and Alliance Health Program. At the same time, PVOs should not repeat not become involved in other

activities which might slow down their training efforts. The main purpose of PVO programs is rapid expansion of trained personnel and AID should support the PVOs and protect them as well so that this purpose is achieved.

5. The role of PVOs may change over time as the Alliance becomes stronger and more capable in the training areas. While AID should encourage the PVOs to concentrate on their training programs in the short run, AID should consider additional roles for PVOs in the medium term.

B. PROJECT OUTPUTS BY LEVEL OF FUNDING

The following three pages contain tables with outputs by year for a minimum health sector program, a moderate program, and a maximum program--based on different funding levels. Financial tables supporting these outputs and all other project costs are found in the Annex.

It should be noted that the rapid impact elements are given priority and longer range impact elements such as medical and nursing education and additional beds for women and children are deferred until project year four and five.

The cost tables in the annex attribute 75% of the project transportation costs to McCollum funding and 25% to AID funding.

TABLE OF PROJECT OUTPUTS BY YEAR: MINIMUM PROGRAM

PROJECT OUTPUTS BY YEAR						
	1	2	3	4	5	TOTAL
<u>No. Students Trained</u>						
First Aides-Alliance	500	900	900	1000	1000	4300
First Aides-PVOs	320	320	320	320	320	1600
Nurses/Medics-Alliance	70	140	140	210	280	980
Nurses/Medics-PVOs	80	80	80	80	80	400
Doctors-Alliance	-	10	10	-	-	20
Doctors-PVOs	10	10	10	-	-	30
Commanders-Alliance	5	10	10	-	-	25
Managerial/Supervisory- Alliance	20	40	40	40	20	160
<u>Additional Health Providers/Facilities in Afghanistan</u>						
First Aides	656	1140	1220	1300	1300	5616
Mobile Emer. Nurses	100	134	134	134	134	636
Mobile Health Clinics	15	30	30	30	30	151
Mobile Surgical Hosp.	4	7	7	7	6	31
Combat Surgical Hosp.	1	3	3	1	0	8
Evacuation Stations	16	16	16	16	16	80
<u>Additional Managers/Supervisory Personnel</u>						
All Types	34	57	60	60	60	271
<u>Vaccination Programs</u>						
Pilot	-	1	-	-	-	1
Regular	-	-	1	-	-	1
<u>Public Education Programs</u>						
Feasibility Study	1	-	-	-	-	1
Programs	-	1	1	1	1	4
<u>Medical/Nursing Education</u>						
Medical students	-	-	-	18	19	37
Nursing students	-	-	-	38	37	75
<u>Additional Beds for Afghans in Pakistan</u>						
Women	-	-	-	75	-	75
Children under age 15	-	-	-	75	-	75

* For inside Afghanistan, expected losses have already been subtracted.

TABLE OF PROJECT OUTPUTS BY YEAR: MODERATE PROGRAM

PROJECT OUTPUTS BY YEAR						
	1	2	3	4	5	TOTAL
<u>No. Students Trained</u>						
First Aides-Alliance	700	1400	1400	1400	1400	6300
First Aides-PVOs	920	920	920	920	920	4600
Nurses/Medics-Alliance	140	210	210	210	210	980
Nurses/Medics-PVOs	210	210	210	210	210	1050
Doctors-Alliance	10	20	15	-	-	45
Doctors-PVOs	10	20	15	-	-	45
Commanders-Alliance	5	20	25	-	-	50
Managerial/Supervisory- Alliance	40	80	80	60	40	300
<u>Additional Health Providers/Facilities in Afghanistan</u>						
First Aides	1296	2180	2320	2320	2320	10436
Mobile Emer. Nurses	116	231	231	231	231	1040
Mobile Health Clinics	20	40	40	50	50	200
Mobile Surgical Hosp.	4	10	10	10	6	40
Combat Surgical Hosp.	1	3	3	3	1	11
Evacuation Stations	24	24	24	24	24	120
<u>Additional Managers/Supervisory Personnel</u>						
All Types	45	76	79	80	81	361
<u>Vaccination Programs</u>						
Pilot	-	1	-	-	-	1
Regular	-	-	1	1	1	3
<u>Public Education Programs</u>						
Feasibility Study	1	-	-	-	-	1
Programs	-	1	1	1	1	4
<u>Medical/Nursing Education</u>						
Medical students	-	-	-	25	25	50
Nursing students	-	-	-	50	50	100
<u>Additional Beds for Afghans in Pakistan</u>						
Women	-	-	-	100	-	100
Children under age 15	-	-	-	100	-	100

* For inside Afghanistan, expected losses have already been subtracted.

TABLE OF PROJECT OUTPUTS BY YEAR: MAXIMUM PROGRAM

	PROJECT OUTPUTS BY YEAR					TOTAL
	1	2	3	4	5	
<u>No. Students Trained</u>						
First Aides-Alliance	900	1800	1800	1800	1800	8100
First Aides-PVOs	1100	1100	1100	1100	1100	5500
Nurses/Medics-Alliance	140	210	280	280	280	1190
Nurses/Medics-PVOs	262	262	262	262	262	1310
Doctors-Alliance	12	25	18	-	-	55
Doctors-PVOs	12	25	18	-	-	55
Commanders-Alliance	6	25	30	-	-	61
Managerial/Supervisory- Alliance	40	80	80	60	40	300
<u>Additional Health Providers/Facilities in Afghanistan</u>						
First Aides	1620	2625	2625	2625	2625	12120
Mobile Emer. Nurses	145	289	289	289	288	1300
Mobile Health Clinics	25	50	50	62	62	249
Mobile Surgical Hosp.	6	13	13	13	7	52
Combat Surgical Hosp.	1	4	4	4	1	14
Evacuation Stations	30	30	30	30	30	150
<u>Additional Managers/Supervisory Personnel</u>						
All Types	45	76	79	80	81	361
<u>Vaccination Programs</u>						
Pilot	-	1	-	-	-	1
Regular	-	-	1	1	1	3
<u>Public Education Programs</u>						
Feasibility Study	1	-	-	-	-	1
Programs	-	1	1	1	1	4
<u>Medical/Nursing Education</u>						
Medical students	-	-	-	30	30	60
Nursing students	-	-	-	60	60	120
<u>Additional Beds for Afghans in Pakistan</u>						
Women	-	-	-	125	-	125
Children under age 15	-	-	-	125	-	125

* For inside Afghanistan, expected losses have already been subtracted.

IV. NON-FINANCIAL ADMINISTRATIVE AND INSTITUTIONAL ARRANGEMENTS

A. ROLES AND COORDINATION AMONG IMPLEMENTATING INSTITUTIONS

At the end of the health planning team visit, the Health Committees of the Seven Party Alliance had made considerable progress and seemed willing to work together. They obviously need funds to do this and they also need technical assistance in getting them started on their way to developing a capability to plan, operate, monitor, and evaluate the larger, more complex health system envisioned by this project. During the discussions, they had made a number of points clear--they wished to be responsible for the Free Afghanistan health system including the administration of health facilities, programs, and evacuation systems inside Afghanistan; salary payments and family support allowances; education and training programs; supply systems; and monitoring and evaluation systems. The organogram of the Alliance Health Committee Secretariat, shown schematically on the following page and developed independently by them, shows their interests and their initial steps in organizational development.

As noted earlier, the PVOs had been meeting together and created an informal organization called the CMC. They had been discussing a number of issues including coordination between the PVOs and the Alliance Health Committee. This remained a major topic of discussion during the health team's visit. As noted earlier, the PVO position initially had been one of minimal contact and maximal independence while the Alliance view was that they should control everything. Discussions with the Alliance led to a modification of their views to allow PVOs to operate training and service activities with the approval of the Alliance. Discussions with many of PVOs receiving some US funds was encouraging but they felt (and the health planning team agreed), that policies and procedures would need to be worked out in some detail as to how approvals would be defined and obtained. This might best be done once the Alliance Health Committee Secretariat is funded. Obviously, the PVOs are reluctant to give up their independence until it is clear that the Secretariat is organized and working satisfactorily. However, the PVOs had also initiated coordination meetings between CMC and the Alliance. The Alliance indicated its further interest in coordination as demonstrated this by the presence of an Advisory Board and a liaison office in their organogram for the Secretariat.

It is also important to note that each PVO has its own policies, its own Board of Directors, and is funded by a number of sources. It should not be expected that all PVOs will agree to many of the changes now being discussed. It is also likely that the Alliance Health Committee will not wish to work with all of the current PVOs carrying out cross-border health programs and, as such, would not approve them. Careful liaison by AID and the technical assistance team will likely be required to maintain the good relationships between the Alliance and the PVOs.

The need for technical assistance has been recognized from the beginning and endorsed by the ANPAC. The recommended technical assistance team composition is the same as in the original document, assuming an Alliance Health Program of moderate or maximum size. In Pakistan, this means a team leader, an operations officer, a training coordinator, and a supply specialist plus various local hire staff. It is envisioned to field a team that has experience in Afghanistan with at least one person experienced in Afghanistan during the war years. It is planned that a majority of the team will be non-Americans--a mixed American, British, French, and Pakistani team being most likely. If the technical assistance team also carries out the role of intermediary (explained in Subsection B following), then one additional expatriate position will be required--a Finance Officer.

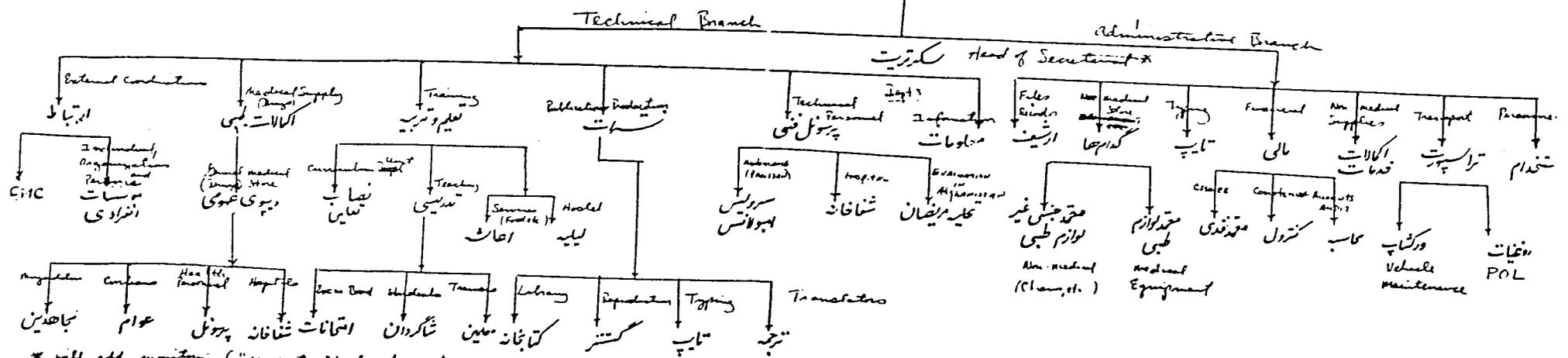
The technical assistance team will operate closely with the Alliance in assisting its organizational development, its training efforts, in helping it coordinate supply and logistics issues, and in relating to the PVOs and to AID and other outside agencies. This help will begin with the development of the first annual work plan and budget, a workshop on training, and other initial efforts requiring further discussion once funding is available (and the amounts are known!). Considerable work will be required in setting up the Secretariat and in developing its internal systems such as personnel, finance, supply, training, and so forth. It is expected that the Alliance and the technical assistance team will share office space although these details remain to be worked out.

In addition to the Alliance, the technical assistance team will work with PVOs. One clear fact that has emerged from discussions during the health team's visit is a desire on the part of the PVOs to have access to technical assistance as they expand their efforts. They have identified needs in curriculum development, pedagogy, and examination procedures, plus public community health planning at the present time. Based on the expectation of many specific needs, considerable short-term technical assistance is built into the technical assistance effort.

During the health planning team's visit, the Government of Pakistan was devoting full efforts to the Geneva VII proximity talks and was unable to give the team any of its own views. As such, this task remains for AID and the Embassy. The GOP did assign a liaison officer to help with scheduling. Not only was the liaison officer an excellent organizer and translator, but his presence clearly demonstrated the importance of close GOP and USG coordination and shared perceptions on how to proceed. The health team hopes that the GOP will strongly endorse the AID activities in the health sector--better yet would be a joint effort.

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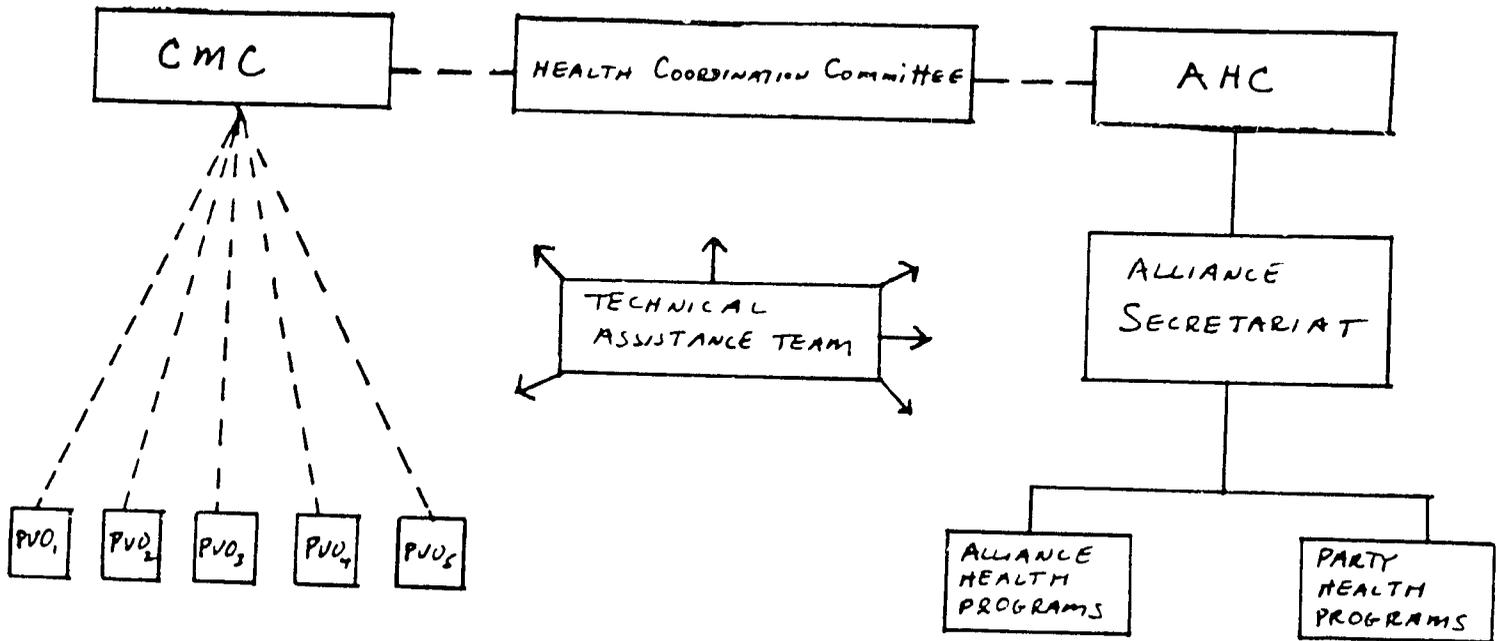
Health Committee Alliance Executive Director
 Alliance Advisory Council
 Advisory Board of Alliance



* will add monitoring ("inspection") department - from Head of Secretariat

SCHEMATIC DRAWING OF THE NON-FINANCIAL ADMINISTRATIVE ARRANGEMENTS IS SHOWN BELOW.

NON-FINANCIAL ADMINISTRATIVE ARRANGEMENTS



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B. COORDINATION BETWEEN THE HEALTH PROJECT SUPPLY SERVICE AND THE COMMODITY EXPORT PROGRAM

The MSH Reference Report included a project supply service operating from Peshawar and staffed by a supply specialist and local staff. The supply service would operate in close coordination with the Swedish Committee for Afghanistan, also located in Peshawar, who have done an excellent job of providing locally procured medical supplies to the mujahiddin. The project supply service would focus on imports from the US or other countries and would grant funds, as required, to the Swedish Committee, for procurement of medicines in support of the Alliance Health Program and PVO programs. The supply service also included a US-based supply specialist to procure medical equipment in the USA and to coordinate with the DOD on McCollum transportation flights.

This report recommends that these arrangements not be changed. Effective control over drugs and medical supplies in Pakistan is crucial not only for prevention of losses but, as importantly, as a tool to encourage movement toward project goals and objectives. It is very important for there to be consistency in drugs, medical equipment, and medical supplies with the Alliance, between the Alliance and the PVOs, and between European and American PVOs. This requires a health project supply service that begins in the US for procurement of medical items and then continues in Pakistan where, in close collaboration with the Swedish Committee, it should provide all equipment sets, expendable supplies, and drugs for both the Alliance Health Program and the PVOs.

How then should the health project supply service relate to the proposed Commodity Export Program (CEP) now under design? It is highly recommended that the CEP contractor coordinate movement of all commodities in the USA and arrange their shipment to Pakistan either through McCollum flights or other mechanisms. In Pakistan, the health project supply service should be separate from the CEP but should investigate the potential for sharing of warehouse space with the CEP.

C. THE IMPLEMENTATION SCHEDULE

The implementation schedule for the first three years was described in the MSH Reference Report. Output levels were based on the budget estimates made at that time. At this point in time, the schedule of events is estimated to be about the same for the first three years.

The project outputs are based on the levels of funding which is unclear at this time and will undoubtedly affect the implementation schedule. Once the project is funded, AID will request the Alliance, with the help of the technical assistance team, to prepare a first year workplan which will serve as the implementation plan to begin activities.

V. FINANCIAL ADMINISTRATION OF AID FUNDS

A. FIVE OPTIONS FOR FINANCIAL ADMINISTRATION OF AID FUNDS AND THEIR ADVANTAGES AND DISADVANTAGES

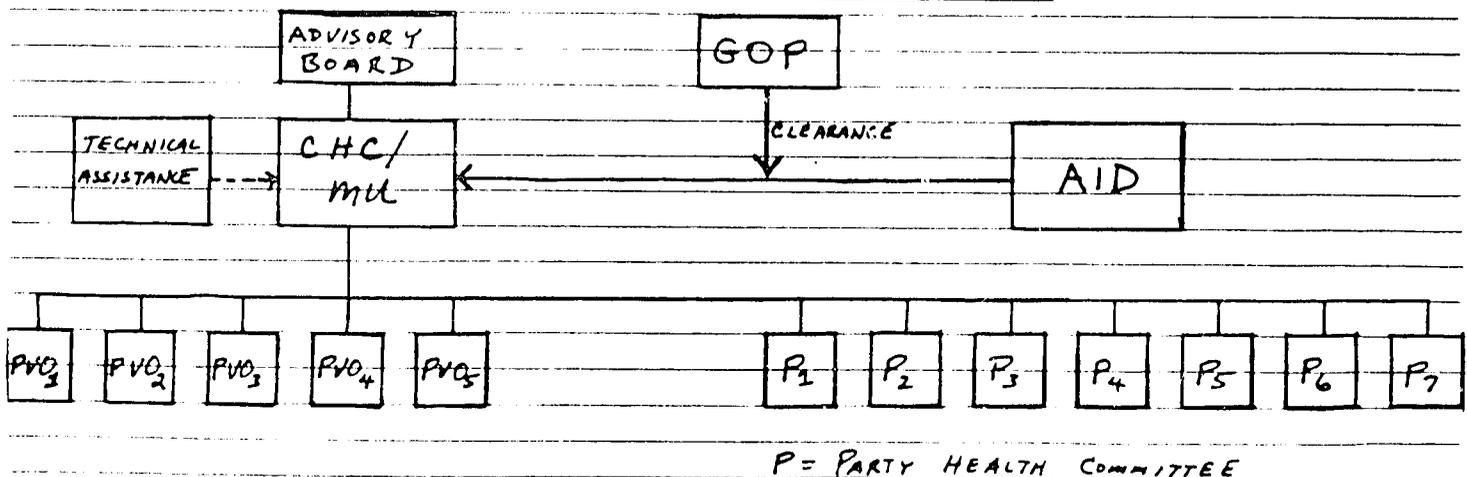
The five major options identified for the financial administration of AID funds in the first year of health activities are listed below. Each will be described and analyzed in the following sections.

SUMMARY OF FIVE MAJOR OPTIONS

- 1 Direct funding of a Coordinated Health Committee Management Unit
- 2 Direct funding of each PVO and direct funding of an Alliance Health Committee Management Unit
- 3 Direct funding of a PVO Health Committee Management Unit and direct funding of an Alliance Health Committee Management Unit
- 4 Direct funding of each PVO and indirect funding of an Alliance Health Committee Management Unit through an intermediary
- 5 Direct funding of each PVO and indirect funding of both the Alliance Health Committee Management Unit and each Party Health Committee through an intermediary

OPTION 1: DIRECT FUNDING OF A COORDINATED HEALTH COMMITTEE MANAGEMENT UNIT

Schematic Representation of Option 1



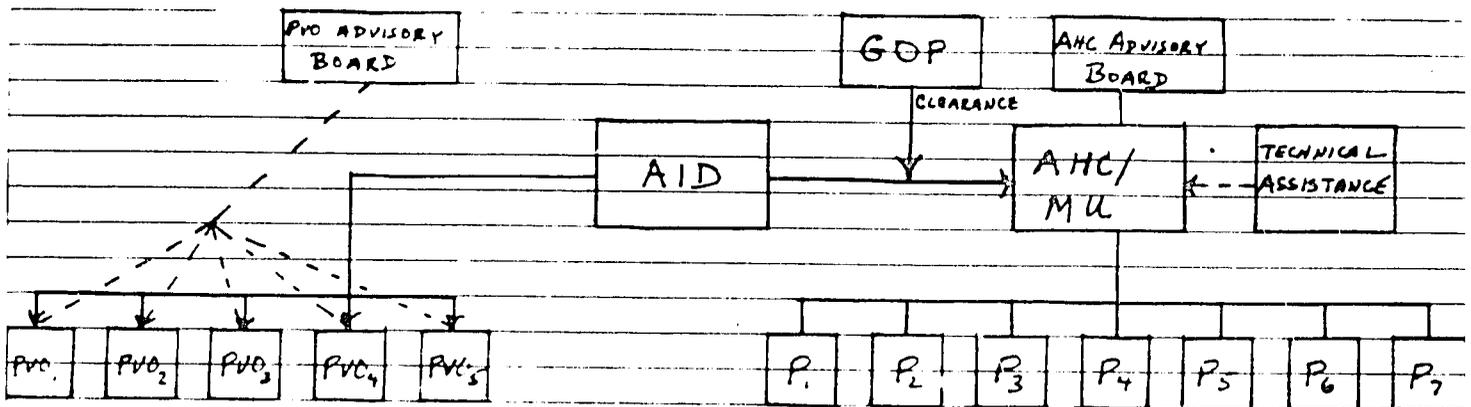
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The main features of this option are that AID would directly fund a Coordinated Health Committee Management Unit (CHC/MU). The CHC/MU would have both party-appointed employees and PVO-appointed employees who work full-time on the CBA health programs. The CHC/MU would have various departments such as training, supply management, health operations, administration, and budget and finance. The CHC/MU would be directed by an Advisory Board which would have both party and PVO representation (AID and the GOP might insist on non-voting observer status). The CHC/MU would disburse funds and commodities to individual PVO's and individual parties and it would be responsible for financial management. Procedures would be worked out for clearance by the Government of Pakistan (GOP) before funds would be granted by AID to the CHC/MU. AID would monitor and audit the overall grant to the CHC/MU and its disbursements to PVOs and parties. Technical assistance would be provided to the CHC/MU but technical advisors would have no authority over granting or monitoring of funds.

The main advantages of this option are that it should promote progressive control of health services by Afghans and should enhance Alliance and PVO interaction. This option should be satisfactory to the Alliance members if they are in the majority. Its disadvantages include an uncertain legal status of this organization to receive direct AID grants (which may be overridden by using the "notwithstanding" clauses of AID's mandate) and the uncertain legal status of this organization in Pakistan; weak current programmatic and financial capability within the party health committee staff and in some PVO staff likely leading to a slow pace of implementation and problems with the quality of training, especially on the Afghan side; and maximum responsibility on the CHC/MU for the supply of medical equipment/drugs with a subsequent serious concern would be whether these commodities would be regularly and properly supplied inside Afghanistan. This option has a stronger potential for diversion of funds and commodities into Pakistan. The development of monitoring systems would be difficult under this option further contributing to concerns about appropriate use of funds and commodities inside Afghanistan. The PVO's would find many disadvantages with this approach including loss of autonomy, cumbersome decision-making, probable foreign staff reductions, and may have concerns about the loss of organizational integrity. From the AID perspective, disbursement would probably be slow and AID would have more limited control as key decisions would be with the Advisory Board and the CHC/MU would directly distribute funds to individual PVO's and Party Health Committees. The CHC/MU meetings might be difficult in many ways including problems over US and other PVO salaries; use of foreign advisors and consultants, differences of opinion on location and control of health facilities and personnel inside Afghanistan, and so forth. The administrative burdens on AID would be high in monitoring of programmatic, commodity, and financial aspects, and accountability problems might dominate the AID-CHC/MU relationship.

OPTION 2: DIRECT FUNDING OF EACH PVO AND DIRECT FUNDING OF AN ALLIANCE HEALTH COMMITTEE MANAGEMENT UNIT

Schematic Representation of Option 2



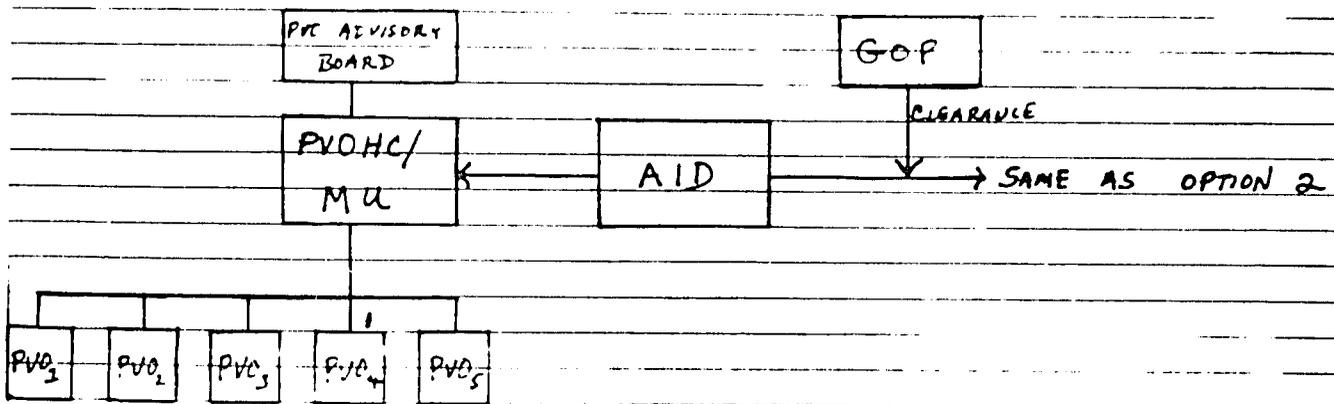
The main features of this option are that AID would directly fund each PVO separately and would directly fund an Alliance Health Management Unit (AHC/MU). The AHC/MU will have an advisory board to make policy decisions, to coordinate activities among themselves, to coordinate with PVOs, and, as required, to meet with AID. The PVOs may wish to have a similar advisory board. However, the flow of funds would be directly to each PVO and directly to the AHC/MU. The Government of Pakistan would clear the granting of funds according to procedures to be worked out between AID and the GOP. The costs of the AHC/MU would be paid for by AID and the AHC/MU would be staffed by Afghans appointed by the AHC Advisory Board. The AHC/MU would have various departments such as training, supply, health operations, administration, and budget and finance. In this option, the AHC/MU would directly disburse commodities and funds to the individual parties for training and health operations inside Afghanistan. Perhaps later on, the AHC/MU may operate Alliance Health Programs inside the country as well. AID would monitor and audit the individual PVO grants and the disbursements of funds and commodities made by the AHC/MU to the parties. Technical assistance would be formally provided to the AHC/MU and would be made informally available to the PVOs. However, the TA team would have no accountability for disbursing or monitoring of funds.

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The advantages of this option are that it should be quite satisfactory to the PVOs and to the Alliance; should enhance the capability of the health committees to plan and implement their programs; and, with AID assistance, should lead to progressive control of the health services by Afghans. The disadvantages of this approach include the uncertain legal status of direct AID grants to the AHC/MU; the weak programmatic and management capability of the health committees at this point in time which could result in a slower pace of expansion of services inside the country; irregular availability of drugs, supplies, and equipment inside Afghanistan; weaker monitoring of health operations; and variable quality of training. The causes of these disadvantages center around the difficulty Afghans will have in disbursing funds and commodities based on adequate performance in use of the funds. For political harmony and cultural reasons, they will more likely disburse on some proportionality-based formula. In addition, the potential for diversion of funds and commodities into party health programs in Pakistan might be increased if the AHC/MU is in an actual disbursement role. This option might lead to rapid disbursement of funds to PVOs and slow disbursement by the Alliance. AID would have good control over PVO funds and more limited control over funds and commodities received by each party through the Alliance. This option places a high administrative burden on AID, especially regarding accountability of funds and commodities and these problems might dominate the AID-Alliance relationship in health.

OPTION 3: DIRECT FUNDING OF A PVO HEALTH COMMITTEE MANAGEMENT UNIT AND DIRECT FUNDING OF AN ALLIANCE HEALTH COMMITTEE MANAGEMENT UNIT

Schematic Representation of Option 3



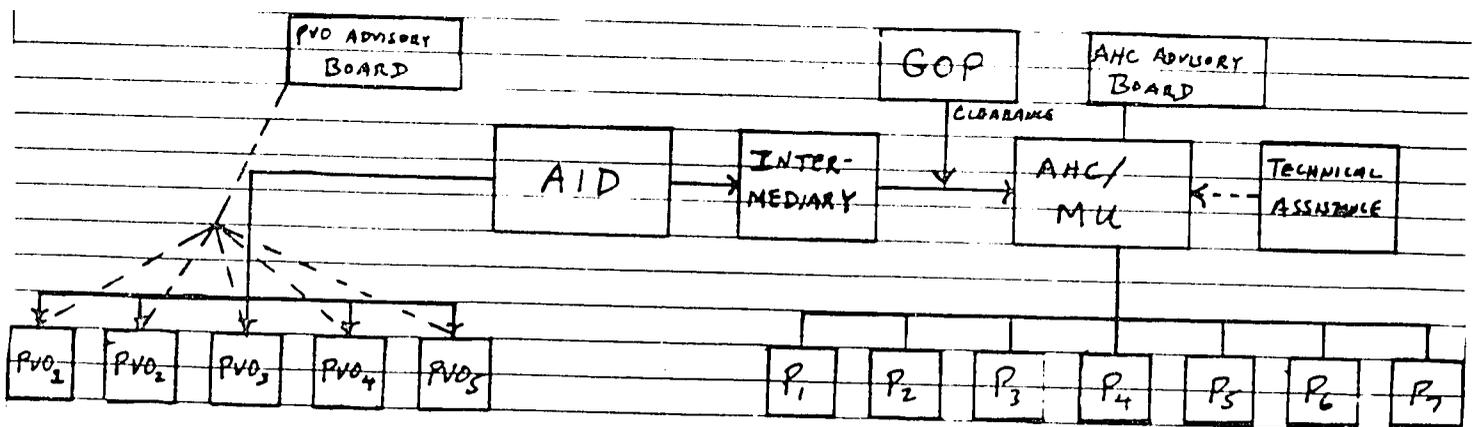
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The main features of this option are that AID would not fund PVOs directly but would instead fund a PVO Health Committee/Management Unit (PVOHC/MU) which would fund the PVOs directly. The PVOHC/MU would have a PVO Advisory Board to make policy and to oversee operations. The PVOHC/MU would have various departments whose staff would be comprised of various PVO members and would be funded by AID. On the Afghan side, the arrangements are the same as in Option 2. AID would monitor and audit grants to the PVOHC/MU and the AHC/MU and would encourage coordination between the committees to maximize the pace of expanded services inside Afghanistan. Technical assistance would be provided to the Alliance and would be made available, on request, to the PVOHC/MU and its members.

The advantages of this approach mainly lie in a formalized coordination among the PVOs. This might result in a more rapid pace of expanded services; better coordinated training, supply, and monitoring systems; and rapid disbursement of funds. Such an approach might make it easier for non-American PVOs to accept AID funds. The disadvantages include registration of a new entity in Pakistan; a weakened role of the AHC/MU vis-a-vis a strengthened PVOHC/MU; weakened AID control; Alliance dissatisfaction; and probable dissatisfaction by the parent headquarters of the individual PVOs.

OPTION 4: DIRECT FUNDING OF EACH PVO AND INDIRECT FUNDING OF AN ALLIANCE HEALTH COMMITTEE MANAGEMENT UNIT THROUGH AN INTERMEDIARY

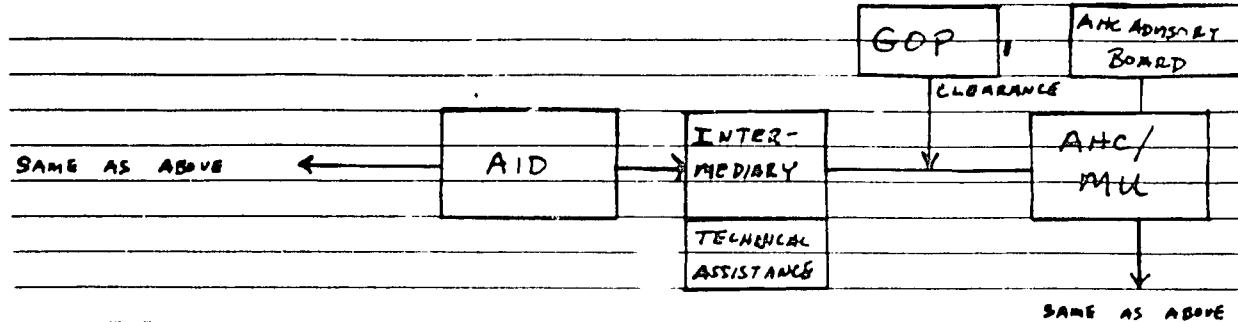
Schematic Representation of Option 4, Variants 1-3



INTERMEDIARY

VARIANT 1	PWI
VARIANT 2	NON-U.S. ORGANIZATION
VARIANT 3	U.S. ORGANIZATION, T.A. SEPARATE

Schematic Representation of Option 4, Variant 4



The main features of this option are that AID would directly fund each PVO directly as in Option 2, but would provide AID funds and commodities to an intermediary who would disburse to the Alliance Health Committee/Management Unit based on mutually agreed plans and disbursement criteria. As before, the AHC/MU would have various departments and an Advisory Board and it would make disbursements to various parties for approved health activities. It may also operate its own health programs over time. The GOP would clear disbursements from the intermediary to the AHC/MU based on established policies and procedures. AID would monitor the intermediary and, on a selected basis, the AHC/MU and the parties. However, the intermediary would have a major role in financial and programmatic monitoring with an expectation of auditable record systems for activities in Pakistan. This option has four variants for the intermediary: (1) Pakistan Welfare International, (2) a non-U.S. organization as intermediary (e.g. a European or Muslim organization), (3) a U.S. organization but different from the technical assistance team, and (4) a U.S. organization that also provides the technical assistance. In Variant 4, the TA team has both an intermediary and a technical role.

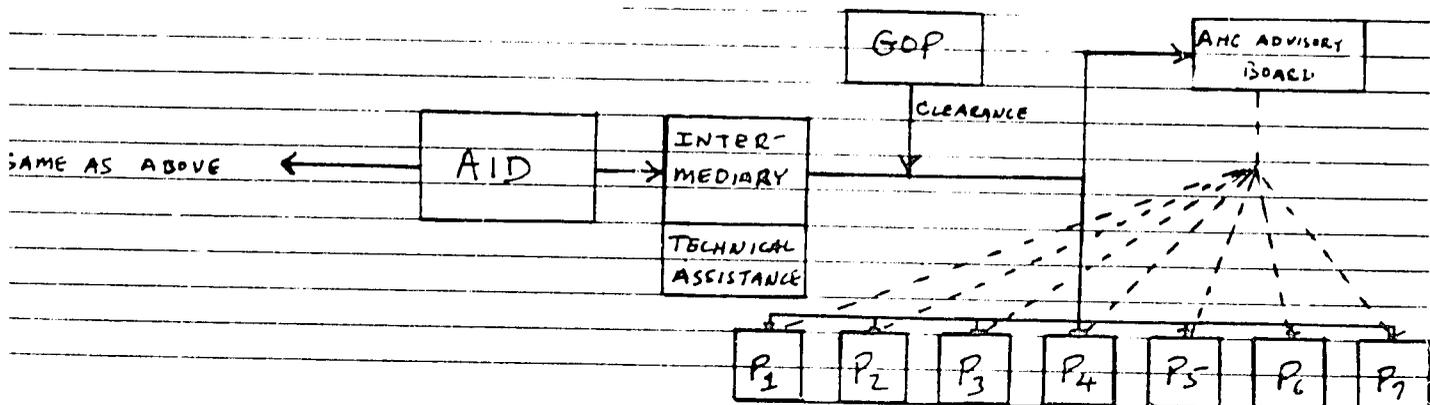
The main advantages of this option are that if the legal problems may be less, particularly if an American intermediary is used; the enhanced control by the intermediary should lead to stronger programmatic and financial management of AID funds and yet, if carried out in a coordinated fashion with the AHC/MU, should lead to enhanced capability of the AHC/MU and progressive control of health services by Afghans over time; and funds and commodities should have a greater likelihood of reaching the planned locations in Afghanistan. In addition, this option, particularly Variant 4, should lead to a rapid pace of expansion of services inside Afghanistan, better quality of training, more regular supplies of medical equipment and drugs, and an adequate monitoring system through close

supervision and control of funds in the first year or so and progressively increasing responsibility to the AHC/MU based on performance. For AID, this option should lead to more rapid disbursement of funds, adequate AID control through the intermediary, a more limited administrative burden, and better accountability of funds and commodities. This option should be satisfactory to the PVOs.

The disadvantages of this approach mainly lie with probable Alliance dissatisfaction, the uncertain position of the GOP on this issue, and increased costs and presence of an intermediary to help manage AID funds.

OPTION 5: DIRECT FUNDING OF EACH PVO AND INDIRECT FUNDING OF BOTH THE ALLIANCE HEALTH COMMITTEE MANAGEMENT UNIT AND EACH PARTY HEALTH COMMITTEE THROUGH AN INTERMEDIARY

Schematic Representation of Option 5



The main features of this option vis-a-vis Option 4 are that the intermediary disburses funds to the AHC/MU for its operations but also disburses funds and commodities directly to each party health committee for its operations based on plans made and approved by the AHC/MU. This option thus provides tighter financial control than Option 4 but otherwise is the same as Option 4 and also has four variants.

The main additional advantage of this option is the tighter control of funds by the intermediary which disburses funds and commodities directly to the Party Health Committees. This may prevent diversion of funds within the AHC/MU, maximize use of funds and commodities within Afghanistan, and increase accountability. The disadvantages are the same as for Option 4--Alliance dissatisfaction, the uncertain position of the GOP, and the higher cost and presence of the intermediary.

B. THE RECOMMENDED OPTION FOR FINANCIAL ADMINISTRATION OF AID FUNDS IN THE FIRST 1-2 YEARS

The table of the following page lists selected criteria for evaluating the five options described above and gives an unweighted score for the options.

Using these unweighted criteria, options 4 and 5 are preferable and these two are recommended--starting with Option 5 while the Alliance Secretariat is forming and moving to Option 4 as soon as possible. However, these scores do not reflect political criteria of either the USG or the GOP.

C. DISBURSEMENT PROCEDURES

The plan is to enter into a Cooperative Agreement or contract with a suitable organization to both act as the intermediary and to provide the technical assistance. The intermediary will keep a separate account of its internal operating expenditures and another account for use by the Alliance. AID would develop a disbursement plan to the intermediary, perhaps on an annual basis against a projected work plan and budget. That plan, once approved by AID, would be cleared with the Government of Pakistan. The intermediary would have developed the annual plan and budget along with the Alliance. The intermediary would disburse funds to the Alliance in small amounts initially, perhaps for one quarter and against specific tasks (Task Order System). As the Alliance demonstrated its capability to use and monitor funds well, the length and amounts of disbursements would be increased. The intermediary will maintain strict accountability of funds in Pakistan and will work with AID to develop accountability standards for inside Afghanistan.

TABLE

SELECTED CRITERIA FOR EVALUATING OPTIONS FOR
FINANCIAL ADMINISTRATION OF AID FUNDS*

CRITERION	OPTION 1	OPTION 2	OPTION 3	OPTION 4	OPTION 5
<u>Organizational</u>					
Legal Status of Imple. Organ.	+	+++	++	++++	++++
Mgt Capability- Programmatic	+	+++	++	++++	+++++
Mgt Capability- Financial	+	+++	++	++++	+++++
Promotes enhanced capability of Health Com.'s	+++	++++	++	+++++	+++++
Promotes progressive control of health services by Afghans	+++++	+++	++	++++	+++++
Max Use of Funds/ Commod. wi Afgh.	+	+++	+++	++++	+++++
<u>Technical</u>					
Rapid Pace of Expanded Services inside Afghan.	+	+++	+++	++++	+++++
Adequate Quality of Training	+	++	+++	++++	++++
Regular Supply of Med Equip/Drug inside Afghan.	+	++	+++	++++	+++++
Adequate monitoring system	+	++	+++	++++	++++
<u>AID-Related</u>					
Rapid Disbursement of Funds	+	+++	+++	+++++	+++++
AID Role and Control	+	+++	++	+++++	+++++
AID Admin. Burden	+	+++	++	+++++	+++++
Accountability of Funds/Commodities	+	+++	+++	++++	+++++
PVO Satisfaction	+	+++++	+++	+++++	+++++
Alliance Satisfaction	+++	+++++	++	++	+
<u>UNWEIGHTED</u>					
SUM OF +'S	24	50	40	67	73

Key: +++++ = strong advantage
 ++++ = advantage
 +++ = neutral/no effect/or offsetting
 ++ = disadvantage
 + = strong disadvantage

* excludes political criteria of both US and GOP

VI. MONITORING AND EVALUATION

In view of the constraints imposed by the lack of an on-going health system in Free Afghanistan and the hostile environment, the monitoring system for health activities inside Afghanistan will be initially limited to collecting and analyzing quantitative information about the output targets and selected milestones that will demonstrate progress in moving toward the targets. Progress toward reaching the targets is subject to the vagaries of war such as supply losses, population movements, and physical losses from battles or bombing. As such, the targets will require regular adjustment based on prevailing conditions and monitoring itself must be based on "reasonable" progress. In addition, the needs for monitoring of services, programs, and numbers or clinics, etc., must be balanced by the need for security in preventing Soviet and DRA forces from gaining information that might cause them to interdict these health activities.

However, output information is needed and, in addition, some subjective measures of the quality of work by the paramedical and first aides will be necessary. Data collection will be done through both formal and informal approaches. The Alliance Secretariat will be one formal mechanism and will have a department of Monitoring and Evaluation. In addition, the Swedish Committee already has a relatively good system for monitoring supply movements and usage by province. This data is helpful in understanding how busy facilities are based on their consumption of supplies. The technical assistance team will help organize and systematize these mechanisms and, in addition, will supplement these approaches with informal interviews with travellers from Afghanistan, both Afghan and foreign. Health activities occurring in Pakistan will be closely monitored.

Routine technical and administrative monitoring will be done by the AID offices in Peshawar and Islamabad in conjunction with the intermediary. AID will require semi-annual and annual reports from the intermediary, the Alliance, and PVOs receiving grants in the health sector. In addition, AID will schedule an outside interim evaluation in the second year of activities. From these approaches AID will develop the criteria to determine whether or not the project should be expanded and when.

RECOMMENDED IMPLEMENTATION ARRANGEMENTS
FOR AID CROSS BORDER HEALTH ASSISTANCE
ACTIVITIES TO IMPROVE THE HEALTH OF
WAR-AFFECTED AFGHANS

ANNEXES

Submitted to
U.S. Agency for International Development
June 10, 1986

By:

John W. LeSar, M.D.
Richard E. Johnson

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- ANNEX 2 A SUMMARY REPORT ON THE ALLIANCE HEALTH COMMITTEE MEETING - 8 May 1986
- ANNEX 3 A SUMMARY REPORT ON THE ALLIANCE HEALTH COMMITTEE MEETING - 15 MAY 1986
- ANNEX 4 A SUMMARY REPORT ON THE COORDINATION OF MEDICAL COMMITTEES MEETING- 18 MAY 1986
- ANNEX 5 A SUMMARY RREPORT OF THE ALLIANCE HEALTH COMMITTEE MEETING - 21 MAY 1986
- ANNEX 6 A SUMMARY REPORT ON THE ALLIANCE HEALTH COMMITTEE MEETING - 25 MAY 1986
- ANNEX 7 A SUMMARY REPORT ON THE COORDINATION OF MEDICAL COMMITTEES MEETING - 25 MAY 1986
- ANNEX 8 PROPOSED TRAINING OF TRAINERS WORKSHOP
- ANNEX 9 MINIMUM ALLIANCE HEALTH PROGRAM BUDGET
- ANNEX 10 MODERATE ALLIANCE HEALTH PROGRAM BUDGET
- ANNEX 11 MAXIMUM ALLIANCE HEALTH PROGRAM BUDGET
- ANNEX 12 MINIMUM PROGRAM BUDGET LINE ITEMS
- ANNEX 13 MODERATE PROGRAM BUDET LINE ITEMS
- ANNEX 14 MAXIMUM PROGRAM BUDGET LINE ITEMS
- ANNEX 15 MODERATE PROGRAM ESTIMATED COSTS-HEALTH TEAM (2 YEARS)

THE ALLIANCE HEALTH COMMITTEE
AND
PRIVATE VOLUNTARY ORGANIZATIONS
4 MAY 1986

Background

Soon after the Soviet invasion of Afghanistan and the beginning of the Jihad, several Private Voluntary Organizations (PVOs) from the free world began arriving in Pakistan to develop various types of cross-border health programs to serve the health needs of the Mujahideen and the civilian population remaining in Free Afghanistan. These cross-border PVO programs include, assigning foreign health care providers, establishing and operating hospitals/clinics, providing medical supplies/equipment and training Afghan paramedics.

In the absence of any combined or united Afghan organizational structure, these PVOs have largely developed independent plans of action that were coordinated with individual commander(s) or selected political parties. During this process, the PVOs have gained considerable experience with running and/or supporting cross-border medical assistance programs, and represent a very valuable resource pool. In fact, the PVOs are the front runners with regards to expanding health care services inside Free Afghanistan.

In addition to PVO health programs, individual political parties have organized health care programs to support the Mujahideen and the general population affiliated with their political party inside Afghanistan. Delivery of services, however, are not well developed, due to the shortage of funds, the lack of trained health care providers and the lack of managerial/logistic skills. Distribution of services are based on party requirements rather than general needs. As a result, a geographical/population imbalance for health coverage has occurred. The ability of the parties to expand services inside Free Afghanistan is further complicated by the fact that the parties also provide health care services for the refugee population in Pakistan, which diverts a significant amount of already scarce human and financial resources away from Free Afghanistan.

With the creation of the Seven Party Alliance to collectively represent the interest of the Mujahideen, their commanders and the civilian population in Free Afghanistan the situation has changed. The Alliance, in recognition of the need for rapidly expanding the health care delivery system on a equitable basis in Free Afghanistan, announced the formation of an Alliance Health Committee (AHC) composed of the Health Committee representatives from each of the Alliance Political Parties in December 1985. The AHC was charged with the responsibility for planning, developing, implementing, monitoring and coordinating an overall health care delivery system for Free Afghanistan.

The PVOs, in an effort to promote coordination among their own organizations as well as with the AHC have established an informal organization called The Coordination of Medical Committees (CMC). The CMC is composed of representatives from each PVO, and holds monthly meeting with the AHC.

Current Situation

Based on the CMC-AHC meeting held on 4 May 1986 and independent discussions with PVO representatives, it was noted that strong differences of opinion exist between AHC and PVO representatives regarding responsibility for planning, organizing and delivering health care services inside Free Afghanistan. On the one hand, the PVOs have indicated that they wish to retain a largely independent status for planning and implementing health care services, while the AHC position is that they have been charged with coordinating and approving all cross-border health activities. The fundamental issue is one of control. The PVOs are proceeding with their plans of action essentially as before the establishment of The Alliance Health Committee and the AHC is trying to assert its authority and mandate to plan and coordinate all cross-border medical assistance activities. Up to this point, however, the AHC has not been able to develop a unified plan or consolidated approach. The reasons are many and complex. Some of the major constraints are shortage of funds, lack of qualified staff and organizational/management skills and the political motives of the individual parties to be seen as the front runners (i.e. one political party does not want to be surpassed in terms of delivery of services by another party).

On the other hand, the PVOs have the capacity, funds and organizational skills to strengthen and expand the health care delivery system inside Free Afghanistan.

The symptoms of this "control issue" have manifested itself in several different ways. For example, several PVOs are currently conducting paramedical training programs for Afghans, and placing or planning to place these trainees in clinics/hospitals according to the need to strengthen their own health facilities and/or plans of action for expansion to new locations. (The Alliance AHC has limited capacity for training and expanding health care delivery services.)

The AHC representatives claim that the selection of trainees and local Afghan trainers by the PVOs has not been coordinated with or approved by the AHC. As a result, the risk of infiltration by Soviet-sponsored agents are high, and the PVOs are not listening to the AHC concerns regarding security. Security factors were the dominant comments, followed by such statements as:

- The PVOs are recruiting trainees from specific areas (commanders) without knowing the overall need for the distribution of services;
- Training of health staff is a party responsibility;
- The Alliance needs to control operations and the external funding according to Alliance needs and security requirements;
- Afghans have the ability to run their own programs;
- The Alliance needs to understand the goals, objectives and political views of the PVOs;
- There should be honesty regarding source of PVO funds;
- The PVOs relatively higher salary structure for Afghan technical staff creates an imbalance and loss of Alliance technical staff to PVOs.
- The collection of monitoring data by a PVO presents a potential security risk, and;
- If all PVOs work under the Alliance, delivery of health services inside Afghanistan will be improved.

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The PVOs have expressed the following views and concerns:

- Party health committees are not organized.
- Clearance of trainees, has been attempted but the parties have failed to follow through.
- Alliance politically motivated and unable to agree on policy issues.
- PVOs do not trust the Alliance to deliver the goods and services as the Alliance is mainly concerned with Peshawar based health services and needs of refugees.
- The selection of trainees/trainers and the delivery of services will be on political grounds rather than need.
- AHC representatives not attending coordination meetings.

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A SUMMARY REPORT
ON
THE ALLIANCE HEALTH COMMITTEE MEETING
8 MAY 1986

The first meeting with The Alliance Health Committee, following the return of the MSH Design Team to complete the design for the Humanitarian Assistance Health Project initiated in November-December, 1985 was held on 8 May 1986. The meeting was attended by Health Committee representatives from all seven Alliance political parties, USAID, MSH, GOP and PWI.

The meeting was opened with a presentation by a USAID representative outlining the scope and the purpose for the return of the MSH team. It was explained that up until two weeks ago, USAID had not received clearance from the GOP to complete the Health Project design. Now that the GOP approval has been received, the MSH team is here for this purpose. As this will be the last opportunity for completing the health project design, important decisions and determinations regarding whether and how this project will be implemented must be made.

The MSH team leader, Dr. Jack LeSar extended greetings to the Alliance, and reviewed the principles discussed with and agreed to by the party leaders in December 1985. AID and the Government of Pakistan reviewed these principles and found them to be acceptable. The principles are as follows:

1. USAID assistance is intended for supporting the objectives of the Jihad, and the preservation of the Afghan culture. Based on your (AHC) recommendations, health care services should be provided equally for war-related casualties and civilian population, as the civilian population is important for the Jihad and morale .
2. USAID assistance will encourage maximum health coverage in the shortest possible time to do the job, as well as to strengthen the responsibility of the Alliance vis-a-vis donors, governments and advisors. Furthermore, the strengthening of party and commander relationships and the Alliance leadership ability in health will be encouraged.

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3. USAID assistance will be directed toward building on the party's current health programs and the contributions made through the PVOs.
4. USAID recognizes that because of the war, the health system must be feasible, practical and flexible, as the Soviet-backed Kabul government will try to disrupt the activities.

Technical discussions will be held on the development of a general health system. Urgent care services, an evacuation system and continuing care services for supporting the injured inside Free Afghanistan. The focus should not be limited only to curative services, but should include discussions on preventive services (e.g. immunizations and tuberculosis). For The Alliance to do this job, additional staff will be needed to support and manage a larger program inside Free Afghanistan.

Training of health care providers will be a high priority, particularly for First Aiders and nurse-paramedics as well as staff for managing and administrating the Alliance health care system. If financing permits, consideration will be given for supporting the training of doctors and nurses.

There will be a requirement for additional drugs, medicines and equipment for setting up a system for supporting mobile teams, clinics, small hospitals and a few larger hospitals.

Most of the above were ideas presented by the parties and written up to help the donor community.

On 12 December, The Seven Party Alliance announced the formation of an Alliance Health Committee composed of Health Committee representatives from each of the seven parties. Before departure, it was understood that The Parties endorsed the above principles and ideas.

The MSH Health Design Report, "AID Cross-Border Humanitarian Assistance Activities to Improve the Health of War-Affected Afghans" was submitted to USAID and GOP in January 1986. USAID has reviewed and approved the Report. Now, the key issues for discussion with the AHC are: how such a program should be administered and managed; how can the experience and services of PVO be best utilized; and what kind of technical assistance will be needed for developing the health plan, supply system, training programs, and management activities. The question is, what is the current situation, and if the ideas and views expressed previously are still valid. The U.S. Government is interested in providing this humanitarian assistance and hopes that this assistance may be approved quickly.

AID Representative

AID Humanitarian Assistance will be budgeted for a two-year period. However, this assistance cannot be provided until approval is received from all concerned: The Alliance, The Government of Pakistan and AID. No one can say how long the approval process might take.

AID Representative

The Alliance should not rely on only one Government or Agency. The assistance (AID) is designed to be in addition to funds now currently received by the Alliance.

AHC Representative

For planning purposes, it is important to know for how long funds will be provided.

MSH Answer

If The Alliance shows its ability to develop the health care systems, the U.S. Government would hope to play a larger role in the future. However, if little progress is shown, it will be difficult to obtain additional funds.

AHC Question

After the report goes to Washington, what will the results be?

AID Answer

The proposal to provide assistance has been approved, but further work is now needed to clearly show (AID) how the assistance will be utilized and services inside Free Afghanistan organized.

MSH Answer

The expected outputs are high and it will take time to reach the targets. A 5-year general plan needs to be prepared with a detailed plan and budget estimates for two years. This will be helpful for AID. When the agreement is signed, the AHC will know exactly what assistance will be made available.

AHC Comment

The AHC will be meeting together in the next couple of days to discuss the points and reach a common decision.

MSH Comment

It is suggested that the AHC meeting, with the aid of maps and population figures, try to decide for the next five years how many clinics will be required and what it takes to do the job.

AHC Representative

All assistance, including the use of AID funds, should be under the control of the parties. As there is a possibility of infiltration by Soviet agents, the PVOs without control are not acceptable. The amount and the volume of AID funds should not be difficult to determine, however, if AID funds are not used according to the wishes of the U.S. Government, the AID funds will be withdrawn.

The security of hospitals and clinics will be jeopardized without the control of the party. The parties must control the operational side, and AID funds should be channeled through parties according to the needs of and security requirements of the parties. For example, IMC is maintaining clinics inside Afghanistan, and their students and teachers have not been identified (cleared) by the party.

AHC Representative II

Agree with the comments above regarding PVOs and the security risk. IMC said that they were not receiving USAID funds, but that is not true. PVOs, like Freedom Medicine, cannot run a program for Afghans. The Afghans people have the ability to run their own programs.

AHC Representative III

Agree with AHC Representatives I and II, regarding PVOs and security. Parties must meet the PVOs to know their political views, and whether they are good. A meeting with the Health Committee representatives will be held soon to discuss these matters.

AHC Representative IV

The AHC must sit together and reach an agreement.

AHC Representative V

In principle, we accept aid from any source as lives are being lost. This process for reaching an agreement and receiving aid should move quickly.

AHC Representative VI

You (AID) wish to help us (AHC), and we wish to receive your aid, but we are concerned about infiltration by Soviet agents.

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AHC Representative VIII

An independent AHC meeting will be held to resolve the issues. The security risk is a problem. For example, someone came with a packet of medicine to be delivered inside Afghanistan. That Caravan was ambushed and most Mujahideen were killed, as there was a security leakage because of a PVO. Further PVOs create salary imbalances, and the parties lose technical staff to the PVOs. AID should be given in coordination with the parties and the Alliance. The PVO trainee selection process is unacceptable.

AHC Representative

AID funds are going directly to PVOs, and AID is not working with The Alliance.

AID Representative

Some PVOs have been given limited support, but they (PVOs) also have to obtain funds from private sources. Your views concerning PVO trainee selection and the possible security risks are helpful. There is a need for better coordination with the PVOs; however, this is now a new beginning and, coordination can be done without money. AID money has been given to PVOs since at the time, there was no mechanism for working with the Alliance. The PVO came directly to AID for funds to help meet some of the needs inside Afghanistan. Hopefully, the Alliance and PVOs can now work together to improve coordination.

MSH Representative

Last year, PVOs went directly to Washington for funds, as the AID office in Pakistan did not exist at that time, and six months ago, the parties were not speaking with one voice. Therefore, PVO financing was selected as a way to help with providing health services inside Afghanistan. PVOs are learning to work with the parties and understand your needs. If your (parties) can speak with one voice, your views will be addressed. If The Alliance can speak with one voice, develop health programs inside Afghanistan, and show by action that the Alliance can use AID funds, AID will be encouraged to give money to the Alliance. When the capability of the Alliance is shown, the role of the PVOs may change.

AHC Representative

PVOs should work under the control of the parties, and the parties should work out a plan and move forward. The Mujahideen will be cleared for training. Security hazards should be avoided.

It was agreed that the next meeting would be held on 15 May, and that the collective views of The Alliance Health Committee would be presented.

SUMMARY REPORT
ON
THE ALLIANCE HEALTH COMMITTEE MEETING
15 MAY 1986

On 15 May 1986, the second meeting with the Alliance Health Committee was held. At this meeting, The AHC submitted for translation and discussion, 8 Principles adopted for guiding the activities of the Alliance in developing and implementing health services inside Free Afghanistan. All Seven Health Committee representatives signed the document listing the 8 Principles, and indicated that these 8 Principles were endorsed by their respective party leaders.

For discussion purposes, the 8 Principles were verbally translated from Dari to English. The formal translation is as follows:

1. The need to give first priority to resistance students as First-Aiders.
2. A singular education program for the training of First-Aiders be drawn up and implemented by The Alliance Health Committee.
3. The recruitment of persons nominated by the parties included in the Alliance to take advantage of First-Aid (training) will occur in accordance with the principles and policy of the AHC.
4. All of A.I.D.'s health assistance be given exclusively to the AHC for the purpose of training health personnel and the provision of health services inside the country; and the above mentioned programs be implemented by the AHC.
5. Cash assistance be paid to technical personnel, First-Aiders, technicians, nurses, and doctors when they are under training and conducting their duties in the homeland.
6. Employment of technical personnel inside of the country within the framework of the Health Committee of the Alliance can occur only after approval of the AHC.
7. The appointment of technical personnel is dependent on the needs of the Mujahideen for health centers and follows consultation with the military committee of the resistance parties within the Alliance and the decision of the health committee.
8. The AHC deems necessary the availability of dormitories for students undergoing training in health courses.

DISCUSSION

MSH Question

Have you (AHC) decided to limit training to First Aiders only?

AHC Answer

First Aiders were mentioned as they are urgently required. However, all categories of workers are included and should be trained for work inside Free Afghanistan.

MSH Question

Is the plan to concentrate on First Aider training now and doctors and nurses later?

AHC Answer

Yes. The initial emphasis is on training First Aiders.

AHC Clarification Principle 2

There should be a standardized approach for training and a standardized curriculum. In addition, supplies, drugs and equipment should be standardized.

AHC Clarification Principle 3

All trainees should be selected through The Alliance Health Committee. Individual parties, not commanders, should recommend trainees to the AHC for selection.

MSH Question

Is this for all trainees regardless of the source of funds?

AHC Answer

AHC needs to discuss this matter further. At the moment however, this refers to training programs supported with AID funds.

MSH Question

Would PVO programs be expected to follow this selection procedure?

AHC Answer

Principle 4 answers this question.

Principle 4MSH Question

Will all AID fund have to go through the AHC, or may the funds go directly to a Party?

Answer

The AHC needs to discuss this further, however, the best way for channeling funds is through the Alliance rather than individual parties.

MSH Comment

It should be noted that PVOs have to work according to their own policies and that they receive funds from many sources. It was suggested that the AHC make the decisions but have many groups carrying out the decision.

AHC Response

This needs further discussion.

Principle 5

It was emphasized that salaries should be paid to technical staff only after working inside, but that trainers working in Pakistan would be eligible.

Principle 6

This point was clear and required no further discussion.

Principle 7MSH Comment

It is important that the AHC draft a simple health plan based on population, Muhaideen locations and distances between health facilities. A decision regarding the type of health services (e.g. only Mujahideen or both Mujahideen and civilians). The AHC has to decide who will do what, when and where. (Note: A AHC member explained that Mujahideen refers to all people residing in Afghanistan. It may be a soldier or any person who provides food, shelter, water or, in any way supports the resistance movement.)

Principle 8

Residential accommodations must be provided for all trainees.

A SUMMARY REPORT
ON
THE COORDINATION OF MEDICAL COMMITTEES (CMC)
18 MAY 1986

On 18 May 1986, a meeting was held with CMC representatives (the IMC, the Freedom Medicine, the MTA, the Austrian Relief Committee and the Swedish Committee) to brief them, and obtain their views on:

- a. The options proposed for the administrative and institutional arrangements through which implementation will occur.
- b. The 8 Principles of Agreements reached between the seven parties (Health Committees) of the Alliance for the cross-border medical assistance.

Discussion

With regards to the administrative and institutional arrangements, the PVOs clearly favored direct funding by AID for each PVO, rather than through an intermediary or management unit. Although it was mentioned that technical assistance, including short-term consultants, would be made available to the PVOs on a request basis, it was suggested that technical assistance (T.A.) (non-financial) be formally included as a part of the T.A. teams regular responsibilities.

The CMC stated that the contribution of the PVOs for organizing and providing direct medical assistance to the Mujahideen and the civilian population in Free Afghanistan should be understood by the Alliance Health Committee. Right from the beginning of the resistance movement, PVOs were actively seeking and receiving private donations for medical relief inside Afghanistan, and it is expected that funds from private sources will continue to be made available for this work. In addition, PVOs have organized and continue to organize public support programs to persuade friendly governments to provide and/or increase their financial aid for humanitarian assistance in Free Afghanistan. Furthermore, the Alliance Health Committee should understand that the PVO receives only a stipend, not a salary, and maintain an apolitical position vis-a-vis the political parties.

Now that substantial new funds may be made available to The Alliance for health activities inside Free Afghanistan, the PVOs realize that medical relief activities will be expanding through the Alliance Health Committees, and they (PVOs) are interested in sharing their knowledge and experience to help the Alliance with this expansion. The PVOs wish to develop their programs to compliment the work of the Alliance/parties and avoid misunderstandings which may constrain the delivery of health care services.

The PVOs have recognized the need for collectively strengthening their coordination activities with the Alliance, as well as the need to work among themselves for improved utilization of their own human and financial resources. Because the individual PVOs are fully engaged with running their own programs and do not have sufficient time for this important work, a Coordination of Medical Committees(CMC) was established. In order for the CMC to work effectively, additional staff is required, and the PVOs are now exploring ways in which such a staff may be acquired.

With regards to The 8 Principles adopted by The Alliance Health Committee, the PVOs general views and comments were as follows:

Principle I

The training of First Aiders and nurse/paramedic should be the top training priority.

Principle II

There should be a standardized training manual for First Aiders and nurse/paramedics. Also, the core skills required for these workders should be defined.

Principle III

In principle, it was agreed that the selection of trainees should be made by the combined Alliance Health Committee. However, the trainee selection should be made on a merit basis and according to geographic need. The following selection procedure was suggested:

1. Each trainee candidate will be required to have a letter of recommendation signed by the party and the local commander.
2. The number of trainees recommended should exceed the training quota for screening purposes (potential learning ability).
3. Final selection will be based on merit as determined by concerned PVO.

Principle 4

It as agreed that the health facilities should be run by Afghans (Alliance Parties) and supported by PVOs as required. However, the Alliance Health Committee will be expected to prepare a plan designating the location and type of health care facility needed for coordination with the PVOs.

Principle 5

Agreed.

Principle 6

As The Alliance Health Committee recommends the trainee, it is assumed that clearance for employment has already been given.

Principle 7

It was agreed that this is an internal Alliance matter and should not concern the PVOs.

Principle 8

Agreed.

In conclusion, it was felt that implementation guidelines should be flexible, open for compromise, and not too complicated so that the development of health care services will not be delayed.

SUMMARY REPORT
ON
THE ALLIANCE HEALTH COMMITTEE MEETING
21 MAY 1986

The third Alliance Health Committee meeting, attended by representatives from all seven political parties, was held on 21 May 1986. The AHC presented five agenda items for discussion and clarification. The five-agenda items were in general as follows; however, it should be noted that the Dari to English translation was not clear.

1. The Alliance Health Committee is the official body designated for planning and implementing AID assisted health programs in (Free Afghanistan) as well as outside (Pakistan). If additional health manpower is required for implementation, technical staff, available through the PVOs, can be employed according to AHC policies and needs.
2. The Alliance agrees with the recommendation to form a Secretariat for planning and implementing the Alliance health programs. Discussions within the Alliance about what policy guidelines should be adopted for such a Secretariat are now underway.
3. The AHC wishes to know the views of the PVOs regarding The 8 Principles adopted by the AHC for planning and implementing health programs for Free Afghanistan. (The AHC submitted The 8 Principles at the 15 May meeting and gave an approval for discussing them with the PVOs.)
4. The AHC requests further information about the "coordinated approach" for discussion and understanding.
5. Further discussion regarding the appropriate salary structure for the health staff working inside Afghanistan are required. For this discussion, the salaries currently paid by the different parties have been obtained.

Discussion

Agenda Item I

The AHC was requested to explain if all assistance from whatever source for health programs would be channeled through the AHC. The answer to this question, however, was vague. Generally, the opinion of the AHC was that the decision would be made on an individual basis.

Agenda Item II

With regards to the Secretariat, it was explained that when AID funds are available, the Secretariat would be responsible for preparing a detailed work plan, indicating what the Alliance would do collectively as well as each individual party. Based on that plan, funds would be provided for carrying out the planned activities. First, however, there should be an overall 3-5 year health plan with some reasonable targets, followed by a detailed plan for the first year.

As the AHC, in addition to their own separate duties and responsibilities, probably would not have sufficient time for carrying out Secretariat functions; it was suggested that the AHC function as an Advisory and Approving Board for the Secretariat, and appoint a full-time Secretariat staff to work under the jurisdiction of the AHC Board. Each party could, for example, appoint one full-time staff, chosen on the basis of technical skills (i.e. a doctor, an experienced administrator, etc.) Further, it was suggested that the Secretariat be organized into departments to focus on specific functional areas such as planning, budget, administration, training and operations. There are many jobs to be done (e.g. salary payment, supplies, training plans, standardization of the curriculum, and preparing training manuals).

The AHC requested clarification on whether the Secretariat would be only an Alliance activities, or would there be AID support? It was explained that the Secretariat should be an Afghan organization, but it was expected that assistance may be required for carrying out some of the technical/administrative responsibilities (e.g. training, supply, planning and administration of the funds). For this, USAID would fund a technical assistance (T.A.) team to work with the AHC board and the Secretariat. The T.A. team's job would be to support the goals and objectives of the Secretariat (e.g. planning, implementation, the decision-making process, and coordination). If, for example, it was found that a PVO was not following the agreed approach, the T.A. team could assist with resolving the issue.

The T.A. team's job will be to give advice, which may or may not be accepted. However, the team will also be working on behalf of AID to help with the disbursement of funds in accordance with (AID) rules. In the beginning, the T.A. team may have more responsibility, but over time, this responsibility should decrease as the capacity of the Alliance to assume the financial responsibility increases. Hopefully, there will be few problems, but the competition for the limited funds may be high, and this can cause problems. As more funds become available, the Alliance will have to decide how to spread the money (among the parties), and help will be needed for this.

AHC Question

Is there a shortage of money?

MSH Answer

There is no shortage of funds to get the work done, but a general plan is required.

AHC Question

Will AHC decisions also require AID approval?

MSH Answer

The concern is that initially it will not be easy for the AHC to make timely decision; however, as soon as AHC is able to do so, then AID should give maximum control to The Alliance.

Agenda Item III

The 8 Principles agreed to by the AHC were presented and discussed with the PVOs at a meeting held on 18 May 1986. The views expressed by the PVOs were explained to the AHC. See Annex 4 for details.

AHC Comment

One party representative expressed concern that some PVOs, who have registered with The Government of Pakistan for refugee activities, are also working inside Afghanistan, and received financial support from USAID.

AID Answer

It was explained by Mr. Crandall that AID and other governments do provide financial assistance to PVOs. It is important to remember that the PVOs working here for the Afghans have also carried out public information campaigns about the needs of the Afghans in Europe and the U.S. Without PVO support in their home country, the Afghan resistance movement would not have the level of support they now receive in the U.N.

In conclusion, it was decided that the final meeting with the MSH team would be held on 25 May 1986. The topics/issues to be discussed are:

1. The proposed administrative arrangements;
2. The Coordinated Approach;
3. PVO issues;
4. The proposed Secretariat.

SUMMARY REPORT
OF
THE ALLIANCE HEALTH COMMITTEE
25 MAY 1986

The fourth and final meeting for the design phase of the AID Cross-Border Health Assistance Activities was held on 25 May 1986. The meeting was attended by Health Committee representative(s) from all seven political parties of the Alliance, the G.O.P., USAID, and the MSH. The agenda was as follows:

1. Presentation of Alliance Health Committee(AHC) recommendations;
2. Presentation/discussion of the recommendations for administrative and coordination arrangements;
3. Proposal for a training of trainers workshop;
4. Recommended activities for the Alliance over the next four months.

Agenda Item I

Since the last meeting with the AHC, the AHC met independently to discuss their views regarding the establishment of an Alliance Health Secretariat. Their recommendation for the Secretariat was presented in the form of an organogram, showing line responsibility for a technical branch and an administrative branch. As the organogram was defined in Dari, the AHC gave a verbal translation and explanation as required. The MSH team leader congratulated the AHC for preparing a carefully considered and comprehensive organizational plan, technical as well as administrative, for the proposed Health Secretariat.

The second point presented by the AHC under Agenda Item I was concerned with further clarification and revision of the 8 Principles adopted by the AHC. The changes and revisions are as follows:

<u>PRINCIPLE NO.</u>	<u>CHANGE/STATEMENT</u>
1	Add mid-level health worker for priority training.
2	Add mid-level health workers for training by Alliance.
3	No change.
4	The AHC reaffirms the original statement and add to the statement those PVOs who implement health services inside Afghanistan must have the agreement of the AHC before carrying out the services.
5	No change.
6	No change.
7	Add civilians with Mujahideen.
8	No change.

CommentsMSH Question

If PVOs provide support to a clinic(s) inside Afghanistan, should that clinic(s) be operated in the name of the PVO, a party or the Alliance?

AHC Answer

Clinic(s) operated/supported inside Afghanistan by PVOs will be in the name of the Alliance; however, the PVOs must obtain clearance from The Alliance Health Secretariat for activities inside Afghanistan.

Agenda Item II

The MSH team leader provided written statements for The Administrative Arrangements and Flow of AID Funds for The Alliance Health Program with a schematic diagram showing the Non-Financial Administrative Arrangements.

The official G.O.P representative was requested to give a verbal translation of the document, as the topics covered were discussed with the AHC previously. It was explained that the schematic diagram is for technical assistance, which will be made available to all, both long-term and short-term technical advisors. Funds for the T.A. will be separate from the funds for health activities.

Comment Regarding Statement No.6 in the AttachmentAHC Comment

It is not necessary to mention parties as they are all part of the Alliance.

MSH Comments

Funds will be provided to the Alliance as well as parties for delivering health services. What are your recommendations?

In the beginning, some clinics may be operated by the Alliance and some by the parties. It is recognized, however, that some parties have more (clinics) than others. How this is managed will have to be an Alliance decision.

PVOs can be very helpful for training, and the PVOs might do that (training) best. PVOs primarily receive funds for training, not for operating clinics inside Afghanistan.

AHC Comment

The PVOs have already received funds.

MSH Explanation

The flow of funds was explained in detail. The points were as follows:

1. There will be two budgets: one for the intermediary internal staff, which may not be used for a programtic activities; and a separate budget for Alliance activities.
2. The Alliance budget will be based on a one-year work plan, listing activities to be carried out quarterly, for which funds will be given after approval by AID and GOP. Each task listed should have a budget. Financial records will have to be maintained for the comptroller.
3. Alliance submits an annual budget, and the funds will be released for specific tasks. Funding will be given in advance and replenished the following quarter. As the Alliance gains experience, funds may be released for a 6-month period or longer.
4. AID regulations include an independent audit of all expenditures. The intermediary will help the Alliance with maintaining financial records for the audit.

AHC Question

Who will be the intermediary?

MSH Answer

It is not yet known. It may be MSH or PWI. The GOP will have to consider this in view of their own foreign policy.

Agenda Item IIIProposed Training Workshop

The general purpose and goals for a training of trainers workshop, to include participants from both the Alliance and PVOs, was presented, and comments from the AHC was requested. The proposal generated considerable discussion in Dari/Pushto among the AHC.

It was generally concluded that, if there is such a workshop, it should be Alliance- sponsored with participants invited by the Alliance. It was decided that this proposal should be discussed in detail with Dr. Barakzai who, in turn, would consult with the Alliance Health Committee representatives as they (the AHC) want to decide about the involvement of PVOs. If the workshop is held, it was decided that the first week of August would be an appropriate time.

Agenda Item IVAHC activities over the next four monthsMSH Team Leader

It was recommended that the Alliance leader make a policy statement regarding the proposed assistance for Cross- Border health activities, and to generate support by calling on The American Ambassador and senior contacts in The GOP to let them know how important the Cross-Border assistance program is for the Alliance.

Note: Throughout the meeting, considerable time was spent on the PVO issue as one of the AHC senior representative was not present during the previous meetings.

Attachment to ANNEX 6

May 23, 1986

ADMINISTRATIVE ARRANGEMENT
AND
FLOW OF AID FUNDS FOR
THE ALLIANCE HEALTH PROGRAM

1. For AID-assisted activities in health, it may be useful to have an Alliance Health Committee Secretariat to plan, operate, monitor, and evaluate health programs of the Alliance and health activities of parties where they receive AID funds. This Secretariat will be under the control of the Alliance Health Committee which should mostly be concerned with policy matters and coordination with the CMC and other outside agencies.
2. As you know, the Private Voluntary Organizations (PVOs) have formed a group called the Coordination of Medical Committees (CMC). Since these PVOs are from many different sources of funds, the CMC cannot "control" them in the way the AHC can control the Secretariat. However, the CMC may present the views of the PVOs.
3. It is hoped that the AHC and the CMC may hold regular coordination meetings, and that this might be formalized into a "Free Afghanistan Health Coordination Committee."
4. Technical Assistance may be available to assist all groups with planning, operation, monitoring, and evaluation of an expanded health program for the Free Afghan people.
5. In accordance with discussion between the AHC and the health planning team, the health planning team will recommend to AHC that the 8 Principles recommended by the AHC are sound. Once the detailed implementation procedures and conditions are decided, PVOs receiving AID funds should abide by these principles.

6. The health planning team will recommend that, after the Alliance Secretariat is functioning smoothly, and the Alliance and parties are satisfactorily carrying out the work, AID grants to PVOs shall be mainly limited to training done in coordination with the AHC. It is also hoped that PVOs may participate with the AHC in joint activities to help the people inside Afghanistan. The health planning team will recommend that when the Secretariat is running smoothly, budgetary support for salary costs, family support allowances, procurement of medicines and medical equipment, and transport costs be made available to parties and PVOs only through the Alliance Secretariat.

Flow of AID Funds

The health planning team will recommend that AID provide funds to the Alliance Secretariat through an intermediary organization with offices in Peshawar. The role of the intermediary is to provide strong financial management skills for use of AID funds that will be linked to the performance of the Alliance and individual parties in expanding health services inside Afghanistan !

While the Alliance Secretariat is being organized and until it has a proven record of sound financial planning and financial management, the intermediary will disburse funds in smaller amounts and for shorter periods of time. Payments will, after the start-up period, be linked to performance in carrying out the plans made by the AHC and the Secretariat. Once the Alliance Secretariat demonstrates its capability and honesty, the intermediary will disburse larger amounts of funds and for longer periods of time. After some time, the intermediary may not be needed if the AHC, the Alliance Secretariat, and the individual party health committees can demonstrate that these funds, provided by the American people, are being used to improve the health of people living in Free Afghanistan.

A SUMMARY REPORT
ON
THE COORDINATION OF MEDICAL COMMITTEE MEETING
25 MAY 1986

The final meeting with the CMC was held on 25 May 1986. The meeting was attended by PVO representatives from Freedom Medicine, German Afghan Committee, International Medical Corps, Medical Training for Afghans, and the Swedish Committee.

A briefing was given on the meetings MSH held with the Alliance Health Committee on 21 and 25 May 1986. (For details, see Annex 5 and 6)

Dr. LeSar reviewed the guidelines for PVO and Alliance Health Program Relationships contained in the draft second MSH Report to AID on Afghanistan/C.B.A./ Health 5/24/86. The following points were emphasized:

1. PVOs are necessary and important for meeting the health program objectives, particularly for increasing the number of training programs for health workers. Training will be a funding priority.
2. PVOs should focus on training rather than running clinics and health programs inside Afghanistan.
3. Clinics supported by PVOs inside Afghanistan should be viewed as training centers and part of the training program.
4. PVOs should use the existing supply arrangements (i.e. the Swedish Committee) for locally procured drugs and supplies. For imported supplies, the PVOs should acquire their supplies through the AID Commodity Export Program or a project supply service.
5. Training programs will be evaluated on:
 - a. the quality of training on core skills;
 - b. the number of trainees qualified;
 - c. the cost per graduate.

6. The Alliance health program should be strengthened. Initially, it is expected the training output will be at lower levels but increased over time. The Alliance may concentrate on training First Aiders while the PVOs on paramedics.
7. As the Alliance health program is new, there will be a gradual step-wise increase. Wherever responsibility and control can be given to the Alliance, without hindering or delaying the health program, it should be given, provided it does not slow down the PVO training outputs.
8. The PVOs relationships with the Alliance, will improve once the Alliance becomes busy with gearing up their own health program.
9. The role of PVOs may change over time, but for the next three years the PVOs will definitely be needed for training programs.
10. The level of AID funding is not known at this time, therefore three budgets have been prepared (i.e. minimum, moderate and maximum). If the funds are limited, it is not known how AID program office will proportion the funds.

Comments

With regards to the proposed training of trainers workshop, the PVOs would like to sponsor this activity jointly with the Alliance Health Committee. It was explained that the proposal would be discussed further with an AHC spokesman on 26 May, and the outcome of that discussion would be reported back to CMC.

CMC Comments

1. The PVOs want to work with the AHC.
2. As an intermediary for the health program has not been yet decided, "things" seem to be moving a little too fast.
3. The Alliance seems to have quite a bit of leverage with AID for telling AID how AID should work with the PVOs.

MSH Response

The MSH mandate is to get the Alliance health program moving forward, and to advise AID on how the PVOs should work and AID funding for PVOs. MSH is not to be the intermediary between you and the Alliance. The PVOs need to define the role of CMC and their relationships with the Alliance.

CMC Question

When will the funds be transferred?

MSH Answer

If the project is approved, it is expected that funds for an intermediary will be available by 31 August 1986. A technical assistance team would then be in place around October or November 1986.

CMC Question

Will we (PVOs) continue to operate at this time as we are presently operating?

MSH Answer

Yes. You should continue as changes will not happen very fast. The first year, it is expected, will be slow (for the AHC), and your help is needed for expanding the training programs.

CMC Question

You mentioned that the PVOs should support the AHC, and resolve minor issues. What do you mean?

MSH Answer

Wherever possible, agree to or compromise on issues that will not slow you down.

CMC Question

If we concentrate our program inside Afghanistan in specific areas (clinics operated as training centers), then that negates our plans for an evacuate route.

MSH Answer

You should plan for an evacuation route, as the parties have not thought this problem through.

CMC Question

If the war ends, is there a contingency plan for providing health assistance?

SH Answer

No. Probably no contingency plan has been made for health assistance. This is a political issue. However, through this assistance program, there will be training for Afghans in administration, and how to set up a health care system.

MC Comment

If this plan works, it will be a big change, and it will be good for Afghanistan.

PROPOSED TRAINING OF TRAINERS WORKSHOP

Background

At the wrap-up meeting with the Alliance Health Committee on 25 May 1986, it was proposed that a training of trainers workshop be held jointly for Alliance Health Program trainers and PVO trainers. This proposal was debated for some time by the AHC representatives over the issue of PVO participation. Apparently, the AHC was of the opinion that this workshop would be a PVO-sponsored activity. This point was clarified that the proposed workshop was not to be a PVO sponsored activity, but AID sponsored with PVO participation.

The conclusion was that the AHC would like to sponsor such a workshop and select the participants. As the matter required further discussion, Dr. Barakzai was appointed spokesman for the group, and further details/discussion would be held with Dr. Barakzai on 26 May 1986. It was agreed, however, that if the workshop is held, the first week of August would be an appropriate time.

As one of the goals (i.e. exploring various methods and approaches which may be adopted for strengthening coordination and working relationships between the Alliance and PVOs) was very controversial, a new draft proposal was prepared without this particular goal for discussion purposes. (Note: If Alliance and PVOs participate together, this would promote coordination, and improve relationships without mentioning this as a specific goal). See Attachment for Revised Workshop Proposal.

Meeting

The spokesman, Dr. Barakzai, for the AHC was met on 26 May 1986 and the suggested goals for the proposed workshop were reviewed. Dr. Barakzai's personal opinion was that such a workshop would be helpful for expanding/improving the First Aider and paramedical training programs. However, Dr. Barakzai was of the opinion that some PVOs would not be acceptable. Strong feelings were displayed regarding the fact that the PVOs have considerable resources available for running their training programs, while the Alliance has little (i.e. no funds from AID).

It was explained that MSH would assume the technical responsibility for organizing and conducting the workshop, and that two organizers would be required. It was suggested that the AHC may like to select, from among their group, someone to function as a co-organizer. The response was that the AHC probably would like to assign one or two trainers to assist and learn about organizing a workshop, but not as a co-organizer. The question regarding PVO participation was left open.

The benefit of the workshop, it was explained, would be helpful for improving and expanding the training programs now, rather than waiting several months for possible AID funds and the arrival of a technical assistance team. Dr. Barakzai understands that AID funds are yet to be approved.

Further, it was explained that at least six weeks lead time for materials preparation in the U.S. and three weeks before the workshop date in Peshawar would be needed. Dr. Barakzai said that the advance time in Peshawar would be important for making several contacts with the individual health committees.

In conclusion, Dr. Barakzai said that he would discuss the matter with the AHC in the next day or so and requested Mr. Al Nehoda to call him regarding the AHC's recommendations for a workshop. This message was communicated to Mr. Nehoda.

Discussion

At this time, it is not known whether the AHC will agree to a joint workshop, an Alliance workshop with selected PVOs invited or a workshop for Alliance participants only.

The ideal would be a workshop attended by both Alliance and PVO trainers. However, if this is not agreed to by the AHC, the question is, should the workshop be held, and what are the options?

Option I : Two Separate Workshop: One for the Alliance and One for the PVOs

The positive points for this option are:

1. Training programs are now on-going;
2. Improvement of training skills would have immediate benefit;
3. Work should be started as soon as possible on identifying core skills and a standard curriculum for First Aiders and paramedics. This is important for ensuring that some level of uniformity in skills and knowledge is taught to the present group of trainees.
4. If the workshop is delayed, it may be several months before a technical assistance team is in place, and the training programs will be just that much further behind.

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The negative points are:

1. Separate workshops will not help improve relationships between the Alliance and the PVOs.
2. PVOs may not wish to participate in a separate workshop.
3. A technical assistance team will not be in place to follow-up.

Option II: Alliance Workshop With Selected PVO Trainers

This option would probably further exacerbate the difference between the Alliance and PVOs, and therefore, is not recommended.

Attachment to ANNEX 8

TRAINING OF TRAINERS WORKSHOPA. Introduction

As the training of health manpower, First Aiders and paramedics, has been identified as a high priority need and requirement for the expansion of health care services inside Free Afghanistan, Management Sciences for Health (MSH), on behalf of USAID is willing to provide technical assistance for organizing and conducting a training of trainers workshop.

B. Goal

It is suggested that the goal of the workshop be focused on strengthening training skills and techniques of trainers involved with carrying out training programs for Afghans who will be deployed for delivery of health care services inside Free Afghanistan.

The specific goals suggested are to:

1. begin the process of identifying and defining the tasks (duties and responsibilities) for First Aiders and paramedics;
2. begin defining the core skill requirements and levels for First Aiders and paramedics;
3. provide an orientation to the training materials development/adaptation process; and
4. provide an orientation to the educational methodologies and techniques which facilitate and promote the learning process and skill development of First Aiders and paramedics.

MINIMUM *

ALLIANCE HEALTH PROGRAM BUDGET

	COSTS BY YEAR (\$MILLIONS)					TOTAL
	PROJECT YEAR					
	1	2	3	4	5	
ALLIANCE	3.8	6.9	7.8	8.0	6.7	33.2
TA	1.5	1.4	1.5	1.5	1.6	7.5
TOTAL AID COSTS	5.3	8.3	9.3	9.5	8.3	40.7
McCOLLUM COSTS	.2	1.6	1.6	1.8	1.9	7.1
TOTAL ALLIANCE HEALTH PROG. COSTS	5.5	9.9	10.9	11.3	10.2	47.8

* based on AID Program of \$15 million per annum

MAJOR ASSUMPTIONS

- 1 Transportation costs are 75% paid with McCollum Amendment funds and 25% paid with AID funds.
- 2 PVO grants are not included in this budget but this budget assumes that, once the health program is underway, PVO grants will only include the costs of training of personnel and management of the training program and grant itself. As such, this budget includes salary costs of all health personnel regardless of source of training; all family support allowances; training costs of Alliance; procurement costs of all equipment sets, expendable supplies, and drugs; transport costs; and supply service costs in Pakistan and Afghanistan.
- 3 This budget assumes that PVOs will train up to 1600 first aiders and up to 400 nurses/paramedics during the five year period of this budget, subject to the availability of funds.
- 4 This budget assumes that there will be a health project supply service in Pakistan which, in collaboration with the Swedish Committee, will provide all equipment sets, expendable supplies, and drugs for both the Alliance and the PVOs.

MODERATE

ALLIANCE HEALTH PROGRAM BUDGET

	COSTS BY YEAR (\$MILLIONS)					TOTAL
	1	2	3	4	5	
ALLIANCE	5.2	9.6	10.7	11.2	9.5	46.2
TA	1.5	1.5	1.6	1.6	1.7	7.9
TOTAL AID COSTS	6.7	11.1	12.3	12.8	11.2	54.1
McCOLLUM COSTS	.2	1.9	2.2	2.3	2.5	9.1
TOTAL ALLIANCE HEALTH PROG. COSTS	6.9	13.0	14.5	15.1	13.7	63.2

* based on AID Program of \$30 million per annum

MAJOR ASSUMPTIONS

- 1 Transportation costs are 75% paid with McCollum Amendment funds and 25% paid with AID funds.
- 2 PVO grants are not included in this budget but this budget assumes that, once the health program is underway, PVO grants will only include the costs of training of personnel and management of the training program and grant itself. As such, this budget includes salary costs of all health personnel regardless of source of training; all family support allowances; training costs of Alliance; procurement costs of all equipment sets, expendable supplies, and drugs; transport costs; and supply service costs in Pakistan and Afghanistan.
- 3 This budget assumes that PVOs will train up to 4600 first aiders and up to 1050 nurses/paramedics during the five year period of this budget, subject to the availability of funds.
- 4 This budget assumes that there will be a health project supply service in Pakistan which, in collaboration with the Swedish Committee, will provide all equipment sets, expendable supplies, and drugs for both the Alliance and the PVOs.

MAXIMUM *

ALLIANCE HEALTH PROGRAM BUDGET

	COSTS BY YEAR (\$MILLIONS)					TOTAL
	1	2	3	4	5	
ALLIANCE	6.6	8.6	13.3	12.8	14.0	55.3
TA	1.5	1.6	1.7	1.8	1.9	8.5
TOTAL AID COSTS	8.1	10.2	15.0	14.6	15.9	63.8
McCOLLUM COSTS	.4	2.5	2.7	2.9	3.1	11.6
TOTAL ALLIANCE HEALTH PROG. COSTS	8.5	12.7	17.7	17.5	19.0	75.4

* based on AID Program of \$50 million per annum

MAJOR ASSUMPTIONS

- 1 Transportation costs are 75% paid with McCollum Amendment funds and 25% paid with AID funds.
- 2 PVO grants are not included in this budget but this budget assumes that, once the health program is underway, PVO grants will only include the costs of training of personnel and management of the training program and grant itself. As such, this budget includes salary costs of all health personnel regardless of source of training; all family support allowances; training costs of Alliance; procurement costs of all equipment sets, expendable supplies, and drugs; transport costs; and supply service costs in Pakistan and Afghanistan.
- 3 This budget assumes that PVOs will train up to 5900 first aiders and up to 1350 nurses/paramedics during the five year period of this budget, subject to the availability of funds.
- 4 This budget assumes that there will be a health project supply service in Pakistan which, in collaboration with the Swedish Committee, will provide all equipment sets, expendable supplies, and drugs for both the Alliance and the PVOs.

7% IS THE ASSUMED ANNUAL RATE OF INFLATION
7% IS THE ASSUMED ANNUAL PAY INCREASE

MANAGEMENT SCIENCES FOR HEALTH
ALLIANCE: MINIMUM PROGRAM
BUDGET LINE ITEMS
LAST UPDATE: 5-22-86

	YEAR 1			YEAR 2			YEAR 3			YEAR 4			YEAR 5			PROJECT LIFE	
	QUANTITY	RATE	AMOUNT	QUANTITY	RATE	AMOUNT	QUANTITY	RATE	AMOUNT	QUANTITY	RATE	AMOUNT	QUANTITY	RATE	AMOUNT	QUANTITY	AMOUNT
I. PERSONNEL																	
MALE NURSE	0	\$1,139	\$0	179	\$1,219	\$218,153	289	\$1,304	\$376,868	399	\$1,395	\$556,734	544	\$1,493	\$812,190	1411	\$1,963,945
FEMALE NURSE	0	\$1,139	\$0	2	\$1,219	\$2,437	2.25	\$1,304	\$2,934	2.25	\$1,395	\$3,139	3	\$1,493	\$4,479	10	\$12,990
DOCTOR	63	\$3,418	\$215,334	69	\$3,657	\$252,351	69	\$3,913	\$270,016	69	\$4,187	\$288,917	69	\$4,480	\$309,141	339	\$1,335,758
TECH 1	0	\$1,139	\$0	14	\$1,219	\$17,062	13.5	\$1,304	\$17,605	13.5	\$1,395	\$18,837	13.5	\$1,493	\$20,155	55	\$73,659
VACCINATOR	0	\$760	\$0	14	\$813	\$11,385	14.25	\$870	\$12,399	14.25	\$931	\$13,267	14.25	\$996	\$14,196	57	\$51,247
FIELD SUPERVISORY NURSE	0	\$1,519	\$0	22	\$1,625	\$35,757	22.5	\$1,739	\$39,130	22.5	\$1,861	\$41,869	23.25	\$1,991	\$46,293	90	\$163,049
FIELD SUPERVISORY MEDICAL OFFICE	0	\$3,797	\$0	2	\$4,063	\$8,126	3	\$4,347	\$13,042	3	\$4,651	\$13,954	3	\$4,977	\$14,931	11	\$50,053
PROVINCIAL HEALTH OFFICER	0	\$4,577	\$0	5.25	\$4,897	\$25,711	6	\$5,240	\$31,441	6	\$5,607	\$33,642	5.25	\$6,000	\$31,497	23	\$122,292
REGIONAL HEALTH OFFICER	0	\$4,577	\$0	2.25	\$4,897	\$11,019	2.25	\$5,240	\$11,790	3	\$5,607	\$16,821	3	\$6,000	\$17,999	11	\$57,629
DIRECTOR	3.75	\$4,577	\$17,164	3.75	\$4,897	\$18,365	3.75	\$5,240	\$19,651	3.75	\$5,607	\$21,026	3.75	\$6,000	\$22,498	19	\$98,704
CHIEF	6	\$3,797	\$22,782	8.25	\$4,063	\$33,518	8.25	\$4,347	\$35,864	8.25	\$4,651	\$38,375	9	\$4,977	\$44,794	40	\$175,333
TECH 2	3	\$1,519	\$4,557	3.75	\$1,625	\$6,095	4.5	\$1,739	\$7,826	4.5	\$1,861	\$8,374	4.5	\$1,991	\$8,960	20	\$35,812
ADMIN/CLERICAL	21	\$760	\$15,960	31.5	\$813	\$25,616	31.5	\$870	\$27,409	31.5	\$931	\$29,328	32.25	\$996	\$32,128	148	\$130,440
TOTAL	96.75		\$275,797	356.75		\$465,595	469.75		\$865,974	580.5		\$1,084,283	727.75		\$1,379,261	2232	\$4,270,911
II. FAMILY SUPPORT ALLOWANCES																	
STAFF LIVING IN AFGHANISTAN																	
MALE NURSE	0.33	\$0	\$0	0.33	\$218,153	\$71,990	0.33	\$376,868	\$124,366	0.33	\$556,734	\$183,722	0.33	\$812,190	\$268,023		\$648,102
FEMALE NURSE	0.80	\$0	\$0	0.80	\$2,437	\$1,950	0.80	\$2,934	\$2,347	0.80	\$3,139	\$2,512	0.80	\$4,479	\$3,583		\$10,392
DOCTOR	0.67	\$215,334	\$144,274	0.67	\$252,351	\$169,075	0.67	\$270,016	\$180,910	0.67	\$288,917	\$193,574	0.67	\$309,141	\$207,124		\$894,958
TECH 1	0.22	\$0	\$0	0.33	\$17,062	\$5,631	0.33	\$17,605	\$5,810	0.33	\$18,827	\$6,216	0.33	\$20,155	\$6,651		\$24,308
VACCINATOR	0.33	\$0	\$0	0.33	\$11,385	\$3,757	0.33	\$12,399	\$4,092	0.33	\$13,267	\$4,378	0.33	\$14,196	\$4,685		\$16,912
FIELD SUPERVISORY NURSE	0.50	\$0	\$0	0.50	\$35,757	\$17,879	0.50	\$39,130	\$19,565	0.50	\$41,869	\$20,934	0.50	\$46,293	\$23,147		\$81,525
FIELD SUPERVISORY MEDICAL OFFICE	0.80	\$0	\$0	0.80	\$8,126	\$6,500	0.80	\$13,042	\$10,433	0.80	\$13,954	\$11,164	0.80	\$14,931	\$11,945		\$40,042
PROVINCIAL HEALTH OFFICER	0.90	\$0	\$0	0.90	\$25,711	\$23,140	0.90	\$31,441	\$28,297	0.90	\$33,642	\$30,278	0.90	\$31,497	\$28,348		\$110,763
REGIONAL HEALTH OFFICER	1.00	\$0	\$0	1.00	\$11,019	\$11,019	1.00	\$11,790	\$11,790	1.00	\$16,821	\$16,821	1.00	\$17,999	\$17,999		\$57,629
ADMIN/CLERICAL	0.50	\$15,960	\$7,980	0.50	\$25,616	\$12,808	0.50	\$27,409	\$13,704	0.50	\$29,328	\$14,664	0.50	\$32,128	\$16,064		\$65,220
TOTAL SUPPORT ALLOWANCES			\$152,254			\$323,749			\$401,316			\$484,263			\$587,568		\$1,949,150
III. FIELD ALLOWANCES/ TRAVEL																	
STAFF TRAVEL INSIDE AFGHANISTAN																	
DIRECTOR (152)	65	\$20	\$1,290	129	\$21	\$2,761	129	\$23	\$2,954	162	\$25	\$3,969	162	\$26	\$4,247	647	\$15,221
CHIEF (152)	137	\$20	\$2,745	275	\$21	\$5,874	275	\$23	\$6,286	343	\$25	\$8,398	342	\$26	\$8,966	1371	\$32,268
TECH 2 (202)	93	\$15	\$1,395	186	\$16	\$2,985	186	\$17	\$3,194	233	\$18	\$4,286	233	\$20	\$4,586	932	\$16,447
TOTAL FIELD ALLOWANCES	294.75		\$5,430	589.5		\$11,620	589.5		\$12,434	738		\$16,653	737.25		\$17,799	2949	\$63,936
IV. VACCINATION PROGRAMS																	
VACCINATION PROGRAM																	
						\$10,000			\$225,000			\$0			\$0		\$235,000
V. PUBLIC EDUCATION PROGRAM																	

PUBLIC EDUCATION PROGRAM \$37,500 \$75,000 \$75,000 \$75,000 \$75,000 \$337,500

VI. TRAINING BY COURSE

FIRST AIDER	5	\$10,000	\$50,000	9	\$10,700	\$96,300	9	\$11,449	\$103,041	10	\$12,250	\$122,504	10	\$13,108	\$131,080	43	\$502,925
MALE NURSE	1	\$70,000	\$70,000	2	\$74,900	\$149,800	2	\$80,143	\$160,286	3	\$85,753	\$257,259	4	\$91,756	\$367,023	12	\$1,004,368
DOCTOR	1	\$10,000	\$10,000	2	\$10,700	\$21,400	2	\$11,449	\$22,898	0	\$12,250	\$0	0	\$13,108	\$0	5	\$54,298
COMMANDER	1	\$500	\$500	2	\$535	\$1,070	2	\$572	\$1,145	0	\$613	\$0	0	\$655	\$0	5	\$2,715
MANAGERS/SUPERVISORS	1	\$20,000	\$20,000	2	\$21,400	\$42,800	2	\$22,898	\$45,796	2	\$24,501	\$49,002	1	\$26,216	\$26,216	8	\$183,814
SUBTOTAL	9	\$150,500		17	\$311,370		17	\$333,166		15	\$428,765		15	\$524,318		73	\$1,748,119

VII. MEDICAL/NURSING TRAINING

MEDICAL STUDENTS		\$10,000	\$0		\$10,700	\$0		\$11,449	\$0	10	\$12,250	\$122,504	10	\$13,108	\$131,080	20	\$253,584
DIPLOMA NURSES		\$3,000	\$0		\$3,210	\$0		\$3,435	\$0	20	\$3,675	\$73,503	20	\$3,932	\$78,648	40	\$152,150
SUBTOTAL	0	\$0		0	\$0		0	\$0		30	\$196,007		30	\$209,727		60	\$405,734
TOTAL TRAINING		\$150,500			\$311,370			\$333,166			\$624,772			\$734,046			\$2,153,854

VIII. PROCUREMENT ADDITIONAL UNITS

MOBILE CLINIC	15	\$2,000	\$30,000	30	\$2,140	\$64,200	30	\$2,290	\$68,694	38	\$2,450	\$93,103	38	\$2,622	\$99,620	151	\$355,618
MOBILE SURGICAL HOSPITAL	8	\$180,000	\$1,440,000	7	\$192,600	\$1,348,200	8	\$206,082	\$1,648,656	8	\$220,508	\$1,764,062	0	\$225,943	\$0	31	\$6,200,918
COMBAT SURGICAL HOSPITAL	2	\$300,000	\$600,000	2	\$321,000	\$642,000	2	\$343,470	\$686,940	1	\$367,513	\$367,513	1	\$393,239	\$393,239	8	\$2,689,692
TOTAL ADDITIONAL UNITS	25	\$2,070,000		39	\$2,054,400		40	\$2,404,290		47	\$2,224,678		39	\$492,859		190	\$9,246,227

IX. EQUIPMENT SETS AND EXPENDABLE SUPPLIES

EQUIPMENT SETS

MUJAHED	99,750	\$2	\$199,500	99,750	\$2	\$213,465	0	\$2	\$0	0	\$2	\$0	0	\$3	\$0	199,500	\$412,965
EMERGENCY FIRST AIDER	2,288	\$50	\$114,413	2,288	\$54	\$122,421	2,288	\$57	\$130,948	0	\$61	\$0	0	\$66	\$0	6,864	\$367,782
MOBILE EMERGENCY NURSE	380	\$500	\$190,125	380	\$535	\$203,434	380	\$572	\$217,674	0	\$613	\$0	0	\$655	\$0	1,141	\$611,233
EVAUATION STATION ATTENDANT	46	\$750	\$34,215	46	\$803	\$36,714	46	\$859	\$39,284	0	\$919	\$0	0	\$983	\$0	137	\$110,311
BORDER CLINIC SET	10	\$750	\$7,310	10	\$803	\$7,824	11	\$859	\$9,016	0	\$919	\$0	0	\$983	\$0	20	\$24,153

EXPENDABLE DRUGS AND MEDICAL SUPPLIES

MUJAHED	0	\$0	\$0	0	\$0	\$0	0	\$0	\$0	0	\$0	\$0	0	\$0	\$0	0	\$0
EMERGENCY FIRST AIDER	342	\$400	\$136,800	2,738	\$428	\$1,171,650	2,738	\$458	\$1,253,666	2,738	\$490	\$1,341,422	2,738	\$524	\$1,435,322	11,292	\$5,338,859
MOBILE EMERGENCY NURSE	0	\$1,582	\$0	341	\$1,693	\$577,648	342	\$1,811	\$619,441	343	\$1,938	\$664,256	343	\$2,074	\$710,754	1,369	\$2,572,098
EVAUATION STATION ATTENDANT	6	\$400	\$2,400	51	\$428	\$21,928	51	\$458	\$23,356	52	\$490	\$25,358	53	\$524	\$27,527	212	\$100,469
MOBILE CLINIC	0	\$3,165	\$0	51	\$3,387	\$172,714	51	\$3,624	\$184,804	51	\$3,877	\$197,740	52	\$4,149	\$214,694	205	\$769,952
MOBILE SURGICAL HOSPITAL	1	\$7,901	\$5,926	11	\$8,454	\$107,789	13	\$9,046	\$115,335	13	\$9,679	\$123,408	14	\$10,357	\$139,814	53	\$492,272
COMBAT SURGICAL HOSPITAL	1	\$12,642	\$9,482	3	\$13,527	\$40,581	3	\$14,474	\$43,421	4	\$15,487	\$58,076	4	\$16,571	\$62,142	14	\$213,702
BORDER CLINIC	15	\$400	\$6,000	15	\$428	\$6,420	15	\$458	\$6,869	15	\$490	\$7,350	15	\$524	\$7,865	75	\$34,504
TOTAL EXPENDABLE SUPPLIES		\$706,270			\$2,682,489			\$2,643,815			\$2,417,611			\$2,598,116			\$11,048,300

X. TRANSPORT COSTS BY TYPE OF EQUIPMENT

MUJAHED	748	\$4.73	\$3,539	3,554	\$5.06	\$17,985	3,554	\$5.42	\$19,244	3,554	\$5.79	\$20,591	3,554	\$6.20	\$22,032	14,962	\$83,389
EMERGENCY FIRST AIDER	7,439	\$4.73	\$35,184	56,204	\$5.06	\$284,456	56,204	\$5.42	\$304,368	56,204	\$5.79	\$325,674	56,204	\$6.20	\$348,471	252,256	\$1,298,154

MOBILE EMERGENCY NURSE	0	\$4.73	\$0	13,452	\$5.06	\$68,082	13,452	\$5.42	\$72,848	13,452	\$5.79	\$77,947	13,452	\$6.20	\$83,403	53,808	\$302,280
EVACUATION STATION ATTENDANT	241	\$4.73	\$1,139	1,244	\$5.06	\$6,293	1,244	\$5.42	\$6,734	1,244	\$5.79	\$7,205	1,244	\$6.20	\$7,710	5,215	\$29,081
MOBILE CLINIC	0	\$4.73	\$0	5,740	\$5.06	\$29,049	5,740	\$5.42	\$31,083	5,740	\$5.79	\$33,259	5,740	\$6.20	\$35,587	22,959	\$128,978
MOBILE SURGICAL HOSPITAL	594	\$4.73	\$2,810	7,695	\$5.06	\$38,945	7,695	\$5.42	\$41,671	7,695	\$5.79	\$44,588	7,695	\$6.20	\$47,710	31,374	\$175,724
COMBAT SURGICAL HOSPITAL	839	\$4.73	\$3,969	17,338	\$5.06	\$87,747	12,891	\$5.42	\$69,808	12,891	\$5.79	\$74,694	12,891	\$6.20	\$79,923	56,848	\$316,140
BORDER CLINIC	333	\$4.73	\$1,575	333	\$5.06	\$1,685	333	\$5.42	\$1,803	333	\$5.79	\$1,930	333	\$6.20	\$2,065	1,665	\$9,058
TOTAL TRANSPORT COSTS			\$48,215			\$534,243			\$547,559			\$585,888			\$626,900		\$2,342,804
11. SUPPLY SERVICE SET-UP																	
SUPPLY SET-UP			\$200,000			\$75,000			\$75,000								\$350,000
111. ADDITIONAL BED/EQUIPMENT; AFGHANS IN PAKISTAN																	
BEDS/EQUIPMENT												\$300,000					\$300,000
1111. STUDIES AND CONTINGENCIES																	
STUDIES/CONTINGENCIES			\$150,000			\$200,000			\$200,000			\$200,000			\$200,000		\$950,000
TOTAL PROJECT COSTS			\$3,795,965			\$6,943,467			\$7,783,553			\$8,013,148			\$8,711,549		\$33,247,682
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									\$18,522,985								
									THREE YEAR TOTAL								

7% IS THE ASSUMED ANNUAL RATE OF INFLATION
7% IS THE ASSUMED ANNUAL PAY INCREASE

MANAGEMENT SCIENCES FOR HEALTH
ALLIANCE: MODERATE PROGRAM
BUDGET LINE ITEMS
LAST UPDATE: 5-21-86

	YEAR 1			YEAR 2			YEAR 3			YEAR 4			YEAR 5			PROJECT LIFE	
	QUANTITY	RATE	AMOUNT	QUANTITY	RATE	AMOUNT	QUANTITY	RATE	AMOUNT	QUANTITY	RATE	AMOUNT	QUANTITY	RATE	AMOUNT	QUANTITY	AMOUNT
I. PERSONNEL																	
MALE NURSE	0	\$1,139	\$0	239	\$1,219	\$291,276	444	\$1,304	\$578,994	649	\$1,395	\$905,565	854	\$1,493	\$1,275,019	2186	\$3,050,855
FEMALE NURSE	0	\$1,139	\$0	3	\$1,219	\$3,656	3	\$1,304	\$3,912	3	\$1,395	\$4,186	4	\$1,493	\$5,972	13	\$17,726
DOCTOR	84	\$3,418	\$287,112	92	\$3,657	\$336,468	92	\$3,913	\$360,021	92	\$4,187	\$385,222	92	\$4,480	\$412,188	452	\$1,781,010
TECH 1	0	\$1,139	\$0	18	\$1,219	\$21,937	18	\$1,304	\$23,473	18	\$1,395	\$25,116	18	\$1,493	\$26,874	72	\$97,400
VACCINATOR	0	\$760	\$0	18	\$813	\$14,638	19	\$870	\$16,532	19	\$931	\$17,690	19	\$996	\$18,928	75	\$67,787
FIELD SUPERVISORY NURSE	0	\$1,519	\$0	30	\$1,625	\$48,760	30	\$1,739	\$52,173	30	\$1,861	\$55,825	31	\$1,991	\$61,724	121	\$218,482
FIELD SUPERVISORY MEDICAL OFFICE	0	\$3,797	\$0	3	\$4,063	\$12,189	4	\$4,347	\$17,389	4	\$4,651	\$18,606	4	\$4,977	\$19,908	15	\$68,091
PROVINCIAL HEALTH OFFICER	0	\$4,577	\$0	3	\$4,897	\$14,692	3	\$5,240	\$15,721	4	\$5,607	\$22,428	4	\$6,000	\$23,998	14	\$76,839
REGIONAL HEALTH OFFICER	0	\$4,577	\$0	3	\$4,897	\$14,692	3	\$5,240	\$15,721	4	\$5,607	\$22,428	4	\$6,000	\$23,998	14	\$76,839
DIRECTOR	5	\$4,577	\$22,885	5	\$4,897	\$24,487	5	\$5,240	\$26,201	5	\$5,607	\$28,035	5	\$6,000	\$29,998	25	\$131,606
CHIEF	8	\$3,797	\$30,376	11	\$4,063	\$44,691	11	\$4,347	\$47,819	11	\$4,651	\$51,166	12	\$4,977	\$59,725	53	\$233,777
TECH 2	4	\$1,519	\$6,076	5	\$1,625	\$8,127	6	\$1,739	\$10,435	6	\$1,861	\$11,165	6	\$1,991	\$11,947	27	\$47,749
ADMIN/CLERICAL	28	\$760	\$21,280	42	\$813	\$34,154	42	\$870	\$36,545	42	\$931	\$39,103	43	\$996	\$42,837	197	\$173,920
TOTAL	129		\$367,729	476		\$889,356	685		\$1,231,156	891		\$1,608,964	1099		\$2,031,114	3280	\$6,128,299
II. FAMILY SUPPORT ALLOWANCES																	
STAFF LIVING IN AFGHANISTAN																	
MALE NURSE	0.33	\$0	\$0	0.33	\$291,276	\$96,121	0.33	\$578,994	\$191,068	0.33	\$905,565	\$298,637	0.33	*****	\$420,756		\$1,006,782
FEMALE NURSE	0.80	\$0	\$0	0.80	\$3,656	\$2,925	0.80	\$3,912	\$3,130	0.80	\$4,186	\$3,349	0.80	\$5,972	\$4,778		\$14,181
DOCTOR	0.67	\$287,112	\$192,365	0.67	\$336,468	\$225,434	0.67	\$360,021	\$241,514	0.67	\$385,222	\$258,099	0.67	\$412,188	\$276,166		\$1,193,277
TECH 1	0.33	\$0	\$0	0.33	\$21,937	\$7,239	0.33	\$23,473	\$7,746	0.33	\$25,116	\$8,288	0.33	\$26,874	\$8,868		\$32,142
VACCINATOR	0.33	\$0	\$0	0.33	\$14,638	\$4,830	0.33	\$16,532	\$5,456	0.33	\$17,690	\$5,838	0.33	\$18,928	\$6,246		\$22,370
FIELD SUPERVISORY NURSE	0.50	\$0	\$0	0.50	\$48,760	\$24,380	0.50	\$52,173	\$26,087	0.50	\$55,825	\$27,913	0.50	\$61,724	\$30,862		\$109,241
FIELD SUPERVISORY MEDICAL OFFICE	0.80	\$0	\$0	0.80	\$24,487	\$19,590	0.80	\$27,389	\$13,911	0.80	\$31,913	\$14,885	0.80	\$37,797	\$15,927		\$64,312
PROVINCIAL HEALTH OFFICER	0.90	\$0	\$0	0.90	\$34,282	\$30,854	0.90	\$41,922	\$37,729	0.90	\$44,856	\$40,371	0.90	\$49,997	\$45,998		\$146,751
REGIONAL HEALTH OFFICER	1.00	\$0	\$0	1.00	\$14,692	\$14,692	1.00	\$15,721	\$15,721	1.00	\$22,428	\$22,428	1.00	\$23,998	\$23,998		\$76,839
ADMIN/CLERICAL	0.50	\$21,280	\$10,640	0.50	\$34,154	\$17,077	0.50	\$36,545	\$18,273	0.50	\$39,103	\$19,552	0.50	\$42,837	\$21,418		\$86,960
TOTAL SUPPORT ALLOWANCES			\$203,005			\$443,142			\$560,334			\$699,558			\$846,816		\$2,752,854
III. FIELD ALLOWANCES/ TRAVEL																	
STAFF TRAVEL INSIDE AFGHANISTAN																	
DIRECTOR (152)	86	\$20	\$1,720	172	\$21	\$3,681	172	\$23	\$3,938	216	\$25	\$5,292	216	\$26	\$5,603	862	\$20,294
CHIEF (152)	183	\$20	\$3,660	366	\$21	\$7,832	366	\$23	\$8,381	457	\$25	\$11,197	456	\$26	\$11,954	1828	\$43,024
TECH 2 (202)	124	\$15	\$1,860	248	\$16	\$3,980	248	\$17	\$4,259	311	\$18	\$5,715	311	\$20	\$6,115	1242	\$21,929
TOTAL FIELD ALLOWANCES	393		\$7,240	786		\$15,494	786		\$16,576	984		\$22,204	983		\$23,732	3932	\$85,248
IV. VACCINATION PROGRAMS																	
VACCINATION PROGRAM																	
						\$10,000			\$300,000			\$300,000			\$300,000		\$910,000
V. PUBLIC EDUCATION PROGRAM																	

PUBLIC EDUCATION PROGRAM		\$50,000		\$100,000		\$100,000		\$100,000		\$100,000		\$100,000		\$450,000			
VI. TRAINING BY COURSE																	
FIRST AIDER	7	\$10,000	\$70,000	14	\$10,700	\$149,800	14	\$11,449	\$160,286	14	\$12,250	\$171,506	14	\$13,108	\$183,511	63	\$735,103
MALE NURSE	2	\$70,000	\$140,000	3	\$74,900	\$224,700	3	\$80,143	\$240,429	3	\$85,753	\$257,259	3	\$91,756	\$275,267	14	\$1,137,655
DOCTOR	2	\$10,000	\$20,000	4	\$10,700	\$42,800	3	\$11,449	\$34,347	0	\$12,250	\$0	0	\$13,108	\$0	9	\$97,147
COMMANDER	1	\$500	\$500	4	\$535	\$2,140	5	\$572	\$2,862	0	\$613	\$0	0	\$655	\$0	10	\$5,502
MANAGERS-SUPERVISORS	2	\$36,000	\$72,000	4	\$38,520	\$154,080	4	\$41,216	\$164,866	3	\$44,102	\$152,305	2	\$47,189	\$94,377	15	\$617,628
SUBTOTAL	14		\$302,500	29		\$573,520	29		\$602,790	20		\$561,070	19		\$553,156	111	\$2,593,035
VII. MEDICAL/NURSING TRAINING																	
MEDICAL STUDENTS	0	\$10,000	\$0	0	\$10,700	\$0	0	\$11,449	\$0	25	\$12,250	\$306,261	25	\$13,108	\$327,699	50	\$633,960
DIPLOMA NURSES	0	\$3,000	\$0	0	\$3,210	\$0	0	\$3,435	\$0	50	\$3,675	\$183,756	50	\$3,932	\$196,619	100	\$380,376
SUBTOTAL	0		\$0	0		\$0	0		\$0	75		\$490,017	75		\$524,318	150	\$1,014,336
TOTAL TRAINING			\$302,500			\$573,520			\$602,790			\$1,051,087			\$1,077,474		\$3,607,371
VIII. PROCUREMENT ADDITIONAL UNITS																	
MOBILE CLINIC	20	\$2,000	\$40,000	40	\$2,140	\$85,600	40	\$2,290	\$91,592	50	\$2,450	\$122,504	50	\$2,622	\$131,060	200	\$470,776
MOBILE SURGICAL HOSPITAL	10	\$180,000	\$1,800,000	10	\$192,600	\$1,926,000	10	\$206,082	\$2,060,820	10	\$220,508	\$2,205,077	0	\$235,943	\$0	40	\$7,991,897
COMBAT SURGICAL HOSPITAL	3	\$300,000	\$900,000	3	\$321,000	\$963,000	3	\$343,470	\$1,030,410	1	\$367,513	\$367,513	1	\$393,239	\$393,239	11	\$3,654,162
TOTAL ADDITIONAL UNITS	33		\$2,740,000	53		\$2,974,600	53		\$3,182,822	61		\$2,695,095	51		\$524,318	251	\$12,116,835
IX. EQUIPMENT SETS AND EXPENDABLE SUPPLIES																	
EQUIPMENT SETS																	
MUJAHED	133,000	\$2	\$266,000	133,000	\$2	\$266,620	0	\$2	\$0	0	\$2	\$0	0	\$3	\$0	266,000	\$550,620
EMERGENCY FIRST AIDER	3,051	\$50	\$152,550	3,051	\$54	\$163,229	3,050	\$57	\$174,597	0	\$61	\$0	0	\$66	\$0	9,152	\$490,376
MOBILE EMERGENCY NURSE	507	\$500	\$253,500	507	\$535	\$271,245	507	\$572	\$290,232	0	\$613	\$0	0	\$655	\$0	1,521	\$814,977
EVACUATION STATION ATTENDANT	61	\$750	\$45,750	61	\$803	\$48,953	61	\$859	\$52,379	0	\$919	\$0	0	\$983	\$0	183	\$147,082
BORDER CLINIC SET	13	\$750	\$9,750	13	\$803	\$10,433	14	\$859	\$12,021	0	\$919	\$0	0	\$983	\$0	40	\$32,204
EXPENDABLE DRUGS AND MEDICAL SUPPLIES																	
MUJAHED	0	\$0	\$0	0	\$0	\$0	0	\$0	\$0	0	\$0	\$0	0	\$0	\$0	0	\$0
EMERGENCY FIRST AIDER	456	\$400	\$182,400	3,650	\$428	\$1,562,200	3,650	\$458	\$1,671,554	3,650	\$490	\$1,788,563	3,650	\$524	\$1,913,762	15,056	\$7,118,479
MOBILE EMERGENCY NURSE	0	\$1,582	\$0	455	\$1,693	\$770,197	456	\$1,811	\$825,922	457	\$1,938	\$885,674	457	\$2,074	\$947,671	1,825	\$3,429,464
EVACUATION STATION ATTENDANT	8	\$400	\$3,200	68	\$428	\$29,104	68	\$458	\$31,141	69	\$490	\$33,811	70	\$524	\$36,702	283	\$133,959
MOBILE CLINIC	0	\$3,165	\$0	68	\$3,367	\$230,285	68	\$3,624	\$246,405	68	\$3,877	\$263,654	69	\$4,149	\$286,258	273	\$1,026,603
MOBILE SURGICAL HOSPITAL	1	\$7,901	\$7,901	17	\$8,454	\$143,719	17	\$9,046	\$153,780	17	\$9,679	\$164,544	18	\$10,357	\$186,419	70	\$656,363
COMBAT SURGICAL HOSPITAL	1	\$12,642	\$12,642	4	\$13,527	\$54,108	4	\$14,474	\$57,895	5	\$15,487	\$77,435	5	\$16,571	\$82,855	19	\$284,935
BORDER CLINIC	20	\$400	\$8,000	20	\$428	\$8,560	20	\$458	\$9,159	20	\$490	\$9,800	20	\$524	\$10,486	100	\$46,066
TOTAL EXPENDABLE SUPPLIES			\$941,693			\$3,576,652			\$3,525,086			\$3,223,481			\$3,464,155		\$14,731,067
X. TRANSPORT COSTS BY TYPE OF EQUIPMENT																	
MUJAHED	998	\$4.73	\$4,718	4,738	\$5.06	\$23,979	4,738	\$5.42	\$25,658	4,738	\$5.79	\$27,456	4,738	\$6.20	\$29,377	19,950	\$111,189
EMERGENCY FIRST AIDER	14,022	\$4.73	\$66,324	74,939	\$5.06	\$379,275	74,939	\$5.42	\$405,824	74,939	\$5.79	\$434,232	74,939	\$6.20	\$464,626	313,779	\$1,750,284

MOBILE EMERGENCY NURSE	0	\$4.73	\$0	17,936	\$5.06	\$90,776	17,936	\$5.42	\$97,120	17,936	\$5.79	\$103,929	17,936	\$6.20	\$111,204	71,744	\$403,040
EVACUATION STATION ATTENDANT	834	\$4.73	\$3,945	1,658	\$5.06	\$8,391	1,658	\$5.42	\$8,979	1,658	\$5.79	\$9,607	1,658	\$6.20	\$10,281	7,466	\$41,203
MOBILE CLINIC	0	\$4.73	\$0	7,653	\$5.06	\$38,733	7,653	\$5.42	\$41,444	7,653	\$5.79	\$44,345	7,653	\$6.20	\$47,449	30,612	\$171,971
MOBILE SURGICAL HOSPITAL	2,493	\$4.73	\$11,792	10,260	\$5.06	\$51,927	10,260	\$5.42	\$55,562	10,260	\$5.79	\$59,451	10,260	\$6.20	\$63,613	43,533	\$242,344
COMBAT SURGICAL HOSPITAL	1,119	\$4.73	\$5,292	5,919	\$5.06	\$29,955	17,188	\$5.42	\$93,077	17,188	\$5.79	\$99,592	17,188	\$6.20	\$106,564	58,600	\$334,480
BORDER CLINIC	444	\$4.73	\$2,100	444	\$5.06	\$2,247	444	\$5.42	\$2,404	444	\$5.79	\$2,573	444	\$6.20	\$2,753	2,220	\$12,077
TOTAL TRANSPORT COSTS			\$94,171			\$625,284			\$730,078			\$781,185			\$835,270		\$3,066,587
II. SUPPLY SERVICE SET-UP																	
SUPPLY SET-UP			\$300,000			\$100,000			\$100,000								\$500,000
III. ADDITIONAL BED/EQUIPMENT; AFGHANS IN PAKISTAN																	
BEDS/EQUIPMENT									\$0			\$400,000					\$400,000
IV. STUDIES AND CONTINGENCIES																	
STUDIES/CONTINGENCIES			\$200,000			\$300,000			\$300,000			\$300,000			\$300,000		\$1,400,000
TOTAL PROJECT COSTS			\$5,206,338			\$9,608,047			\$10,648,824			\$11,181,574			\$9,563,479		\$46,148,262
			=====			=====			=====			=====			=====		=====
									\$25,463,209								
									THREE YEAR TOTAL								

7% IS THE ASSUMED ANNUAL RATE OF INFLATION
7% IS THE ASSUMED ANNUAL PAY INCREASE

MANAGEMENT SCIENCES FOR HEALTH
ALLIANCE: MAXIMUM PROGRAM
BUDGET LINE ITEMS
LAST UPDATE: 5-23-86

	YEAR 1			YEAR 2			YEAR 3			YEAR 4			YEAR 5			PROJECT LIFE	
	QUANTITY	RATE	AMOUNT	QUANTITY	RATE	AMOUNT	QUANTITY	RATE	AMOUNT	QUANTITY	RATE	AMOUNT	QUANTITY	RATE	AMOUNT	QUANTITY	AMOUNT
I. PERSONNEL																	
MALE NURSE	135	\$1,139	\$153,765	270	\$1,219	\$329,057	428	\$1,304	\$558,130	586	\$1,395	\$817,660	744	\$1,493	\$1,110,790	2163	\$2,969,401
FEMALE NURSE	0	\$1,139	\$0	3	\$1,219	\$3,656	?	\$1,304	\$3,912	3	\$1,395	\$4,186	4	\$1,493	\$5,972	13	\$17,726
DOCTOR	84	\$3,418	\$287,112	92	\$3,657	\$336,468	92	\$3,913	\$360,021	92	\$4,187	\$385,222	92	\$4,480	\$412,188	452	\$1,781,010
TECH 1	0	\$1,139	\$0	18	\$1,219	\$21,937	18	\$1,304	\$23,473	18	\$1,395	\$25,116	18	\$1,493	\$26,874	72	\$97,400
VACCINATOR	0	\$760	\$0	18	\$813	\$14,638	19	\$870	\$16,532	19	\$931	\$17,690	19	\$996	\$18,928	75	\$67,787
FIELD SUPERVISORY NURSE	0	\$1,519	\$0	30	\$1,625	\$48,760	30	\$1,739	\$52,173	30	\$1,861	\$55,825	31	\$1,991	\$61,724	121	\$218,482
FIELD SUPERVISORY MEDICAL OFFICE	0	\$3,797	\$0	3	\$4,063	\$12,188	4	\$4,347	\$17,389	4	\$4,651	\$18,606	4	\$4,977	\$19,908	15	\$68,091
PROVINCIAL HEALTH OFFICER	0	\$4,577	\$0	7	\$4,897	\$34,282	8	\$5,240	\$41,922	8	\$5,607	\$44,856	7	\$6,000	\$41,997	30	\$163,056
REGIONAL HEALTH OFFICER	0	\$4,577	\$0	3	\$4,897	\$14,692	3	\$5,240	\$15,721	4	\$5,607	\$22,428	4	\$6,000	\$23,998	14	\$76,839
DIRECTOR	5	\$4,577	\$22,885	5	\$4,897	\$24,487	5	\$5,240	\$26,201	5	\$5,607	\$28,035	5	\$6,000	\$29,998	25	\$131,606
CHIEF	8	\$3,797	\$30,376	11	\$4,063	\$44,691	11	\$4,347	\$47,819	11	\$4,651	\$51,166	12	\$4,977	\$59,725	53	\$233,777
TECH 2	4	\$1,519	\$6,076	5	\$1,625	\$8,127	6	\$1,739	\$10,435	6	\$1,861	\$11,165	6	\$1,991	\$11,947	27	\$47,749
ADMIN/CLERICAL	28	\$760	\$21,280	42	\$813	\$34,154	42	\$870	\$36,545	42	\$931	\$39,103	43	\$996	\$42,837	197	\$173,920
TOTAL	264		\$521,494	507		\$927,137	669		\$1,210,272	828		\$1,521,059	989		\$1,866,884	3257	\$6,046,845
II. FAMILY SUPPORT ALLOWANCES																	
STAFF LIVING IN AFGHANISTAN																	
MALE NURSE	0.33	\$153,765	\$50,742	0.33	\$329,057	\$108,589	0.33	\$558,130	\$184,183	0.33	\$817,660	\$269,828	0.33	*****	\$366,561		\$979,902
FEMALE NURSE	0.80	\$0	\$0	0.80	\$3,656	\$2,925	0.80	\$3,912	\$3,130	0.80	\$4,186	\$3,349	0.80	\$5,972	\$4,778		\$14,181
DOCTOR	0.67	\$287,112	\$192,365	0.67	\$336,468	\$225,434	0.67	\$360,021	\$241,214	0.67	\$385,222	\$258,099	0.67	\$412,188	\$276,166		\$1,193,277
TECH 1	0.33	\$0	\$0	0.33	\$21,937	\$7,239	0.33	\$23,473	\$7,746	0.33	\$25,116	\$8,288	0.33	\$26,874	\$8,868		\$32,152
VACCINATOR	0.33	\$0	\$0	0.33	\$14,638	\$4,830	0.33	\$16,532	\$5,456	0.33	\$17,690	\$5,838	0.33	\$18,928	\$6,246		\$22,370
FIELD SUPERVISORY NURSE	0.50	\$0	\$0	0.50	\$48,760	\$24,380	0.50	\$52,173	\$26,087	0.50	\$55,825	\$27,913	0.50	\$61,724	\$30,862		\$109,241
FIELD SUPERVISORY MEDICAL OFFICE	0.80	\$0	\$0	0.80	\$12,188	\$9,751	0.80	\$17,389	\$13,911	0.80	\$18,606	\$14,885	0.80	\$19,908	\$15,927		\$54,473
PROVINCIAL HEALTH OFFICER	0.90	\$0	\$0	0.90	\$34,282	\$30,854	0.90	\$41,922	\$37,729	0.90	\$44,856	\$40,371	0.90	\$41,997	\$37,797		\$146,751
REGIONAL HEALTH OFFICER	1.00	\$0	\$0	1.00	\$14,692	\$14,692	1.00	\$15,721	\$15,721	1.00	\$22,428	\$22,428	1.00	\$23,998	\$23,998		\$76,859
ADMIN/CLERICAL	0.50	\$21,280	\$10,640	0.50	\$34,154	\$17,077	0.50	\$36,545	\$18,273	0.50	\$39,103	\$19,552	0.50	\$42,837	\$21,418		\$86,960
TOTAL SUPPORT ALLOWANCES			\$253,747			\$445,771			\$553,448			\$670,549			\$792,621		\$2,716,136
III. FIELD ALLOWANCES, TRAVEL																	
STAFF TRAVEL INSIDE AFGHANISTAN																	
DIRECTOR (152)	86	\$20	\$1,720	172	\$21	\$3,681	172	\$23	\$3,938	216	\$25	\$5,292	216	\$26	\$5,663	862	\$20,294
CHIEF (152)	183	\$20	\$3,660	366	\$21	\$7,832	366	\$23	\$8,381	457	\$25	\$11,197	456	\$26	\$11,954	1828	\$43,024
TECH 2 (202)	124	\$15	\$1,860	248	\$16	\$3,980	248	\$17	\$4,259	311	\$18	\$5,715	311	\$20	\$6,115	1242	\$21,929
TOTAL FIELD ALLOWANCES	393		\$7,240	786		\$15,494	786		\$16,578	984		\$22,204	983		\$23,732	3932	\$85,248
IV. VACCINATION PROGRAMS																	
VACCINATION PROGRAM			\$0			\$12,500			\$375,000			\$375,000			\$375,000		\$1,137,500
V. PUBLIC EDUCATION PROGRAM																	

PUBLIC EDUCATION PROGRAM		\$62,500		\$125,000		\$125,000		\$125,000		\$125,000		\$125,000		\$562,500			
VI. TRAINING BY COURSE																	
FIRST AIDER	9	\$10,000	\$70,000	18	\$10,700	\$192,600	18	\$11,449	\$206,082	18	\$12,250	\$220,508	18	\$13,108	\$235,943	81	\$945,133
MALE NURSE	3	\$70,000	\$210,000	4	\$74,900	\$294,600	4	\$80,143	\$320,572	4	\$85,753	\$343,012	4	\$91,756	\$367,023	19	\$1,540,207
DOCTOR	3	\$10,000	\$30,000	5	\$10,700	\$53,500	5	\$11,449	\$57,245	5	\$12,250	\$61,252	5	\$13,108	\$65,540	23	\$267,537
COMMANDER	2	\$500	\$1,000	5	\$535	\$2,675	5	\$572	\$2,862	5	\$613	\$3,063	5	\$655	\$3,277	22	\$12,877
MANAGERS/SUPERVISORS	2	\$20,000	\$40,000	5	\$21,400	\$107,000	5	\$22,898	\$114,490	5	\$24,501	\$122,504	5	\$26,216	\$131,080	22	\$515,074
SUBTOTAL	19		\$371,000	37		\$655,375	37		\$701,251	37		\$750,339	37		\$802,863	167	\$3,280,828
VII. MEDICAL/NURSING TRAINING																	
MEDICAL STUDENTS	0	\$10,000	\$0	0	\$10,700	\$0	0	\$11,449	\$0	20	\$12,250	\$245,009	20	\$13,108	\$262,159	40	\$507,168
DIPLOMA NURSES	0	\$3,000	\$0	0	\$3,210	\$0	0	\$3,435	\$0	32	\$3,675	\$117,604	32	\$3,932	\$125,836	64	\$243,441
SUBTOTAL	0		\$0	0		\$0	0		\$0	52		\$362,613	52		\$387,996	104	\$750,608
TOTAL TRAINING			\$371,000			\$655,375			\$701,251			\$1,112,952			\$1,190,858		\$4,031,436
VIII. PROCUREMENT ADDITIONAL UNITS																	
MOBILE CLINIC	32	\$2,000	\$64,000	65	\$2,140	\$139,100	65	\$2,290	\$148,837	80	\$2,450	\$196,007	80	\$2,622	\$209,727	322	\$757,671
MOBILE SURGICAL HOSPITAL	13	\$180,000	\$2,340,000	13	\$192,600	\$2,503,800	13	\$206,082	\$2,679,066	13	\$220,508	\$2,866,601	13	\$235,943	\$3,067,263	65	\$13,456,729
COMBAT SURGICAL HOSPITAL	4	\$300,000	\$1,200,000	4	\$321,000	\$1,284,000	4	\$343,470	\$1,373,880	2	\$367,513	\$735,026	2	\$393,239	\$786,478	16	\$5,379,383
TOTAL ADDITIONAL UNITS	49		\$3,604,000	82		\$3,926,900	82		\$4,201,783	95		\$3,797,633	95		\$4,063,468	403	\$19,593,784
IX. EQUIPMENT SETS AND EXPENDABLE SUPPLIES																	
EQUIPMENT SETS																	
MUJAHED	166,250	\$2	\$332,500	166,250	\$2	\$355,775	0	\$2	\$0	0	\$2	\$0	0	\$3	\$0	332,500	\$688,275
EMERGENCY FIRST AIDER	3,814	\$50	\$190,688	3,814	\$54	\$204,036	3,813	\$57	\$218,247	0	\$61	\$0	0	\$66	\$0	11,440	\$612,970
MOBILE EMERGENCY NURSE	634	\$500	\$316,875	634	\$535	\$339,056	634	\$572	\$362,790	0	\$613	\$0	0	\$655	\$0	1,901	\$1,018,721
EVACUATION STATION ATTENDANT	76	\$750	\$57,188	76	\$803	\$61,191	76	\$859	\$65,474	0	\$919	\$0	0	\$983	\$0	229	\$183,852
BORDER CLINIC SET	16	\$750	\$12,188	16	\$803	\$13,041	18	\$859	\$15,027	0	\$919	\$0	0	\$983	\$0	50	\$40,255
EXPENDABLE DRUGS AND MEDICAL SUPPLIES																	
MUJAHED	0	\$0	\$0	0	\$0	\$0	0	\$0	\$0	0	\$0	\$0	0	\$0	\$0	0	\$0
EMERGENCY FIRST AIDER	570	\$400	\$228,000	570	\$428	\$243,960	4,563	\$458	\$2,089,443	4,563	\$490	\$2,235,703	4,563	\$524	\$2,392,203	14,828	\$7,189,309
MOBILE EMERGENCY NURSE	0	\$1,582	\$0	0	\$1,693	\$0	570	\$1,811	\$1,032,402	570	\$1,938	\$1,104,670	570	\$2,074	\$1,181,997	1,710	\$3,319,070
EVACUATION STATION ATTENDANT	10	\$400	\$4,000	10	\$428	\$4,280	85	\$458	\$38,927	85	\$490	\$41,651	85	\$524	\$44,567	275	\$133,425
MOBILE CLINIC	0	\$3,165	\$0	0	\$3,387	\$0	85	\$3,624	\$308,007	85	\$3,877	\$329,567	85	\$4,149	\$352,637	255	\$990,211
MOBILE SURGICAL HOSPITAL	1	\$7,901	\$9,876	1	\$8,454	\$10,568	21	\$9,046	\$192,224	21	\$9,679	\$205,680	21	\$10,357	\$220,078	66	\$638,426
COMBAT SURGICAL HOSPITAL	1	\$12,642	\$15,803	1	\$13,527	\$16,909	5	\$14,474	\$72,369	5	\$15,487	\$77,435	5	\$16,571	\$82,855	18	\$265,371
BORDER CLINIC	25	\$400	\$10,000	25	\$428	\$10,700	25	\$458	\$11,449	25	\$490	\$12,250	25	\$524	\$13,108	125	\$57,507
TOTAL EXPENDABLE SUPPLIES			\$1,177,116			\$1,259,514			\$4,406,358			\$4,006,958			\$4,287,445		\$15,137,392
X. TRANSPORT COSTS BY TYPE OF EQUIPMENT																	
MUJAHED	1,247	\$4.73	\$5,898	5,923	\$5.06	\$29,974	5,923	\$5.42	\$32,073	5,923	\$5.79	\$34,316	5,923	\$6.20	\$36,720	24,937	\$138,982
EMERGENCY FIRST AIDER	16,160	\$4.73	\$76,434	93,674	\$5.06	\$474,094	93,674	\$5.42	\$507,280	93,674	\$5.79	\$542,790	93,674	\$6.20	\$580,785	390,856	\$2,181,384

MOBILE EMERGENCY NURSE	0	\$4.73	\$0	22,420	\$5.06	\$113,470	22,420	\$5.42	\$121,413	22,420	\$5.79	\$129,912	22,420	\$6.20	\$139,005	89,680	\$563,800
EVACUATION STATION ATTENDANT	872	\$4.73	\$4,122	2,073	\$5.06	\$10,469	2,073	\$5.42	\$11,223	2,073	\$5.79	\$12,009	2,073	\$6.20	\$12,850	9,162	\$50,693
MOBILE CLINIC	0	\$4.73	\$0	9,566	\$5.06	\$48,416	9,566	\$5.42	\$51,805	9,566	\$5.79	\$55,431	9,566	\$6.20	\$59,311	38,265	\$214,963
MOBILE SURGICAL HOSPITAL	2,549	\$4.73	\$12,058	12,825	\$5.06	\$64,909	12,825	\$5.42	\$69,452	12,825	\$5.79	\$74,314	12,825	\$6.20	\$79,516	53,849	\$300,248
COMBAT SURGICAL HOSPITAL	3,581	\$4.73	\$16,939	18,313	\$5.06	\$92,681	18,313	\$5.42	\$99,169	18,313	\$5.79	\$106,111	18,313	\$6.20	\$113,539	76,831	\$428,439
BORDER CLINIC	555	\$4.73	\$2,625	555	\$5.06	\$2,809	555	\$5.42	\$3,006	555	\$5.79	\$3,216	555	\$6.20	\$3,441	2,775	\$15,097
TOTAL TRANSPORT COSTS			\$118,077			\$836,842			\$895,421			\$958,100		\$1,025,167			\$3,833,607
II. SUPPLY SERVICE SET-UP																	
SUPPLY SET-UP			\$250,000			\$100,000			\$100,000								\$450,000
III. ADDITIONAL BED/EQUIPMENT; AFGHANS IN PAKISTAN																	
BEDS/EQUIPMENT									\$500,000								\$500,000
XIII. STUDIES AND CONTINGENCIES																	
STUDIES/CONTINGENCIES			\$187,500			\$250,000			\$250,000			\$250,000			\$250,000		\$1,187,500
TOTAL PROJECT COSTS			\$6,552,675			\$8,554,532			\$13,335,111			\$12,839,454			\$14,000,175		\$55,281,947
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			=====			=====			=====			=====			=====		=====
									\$28,442,318								
									THREE YEAR TOTAL								

ESTIMATED COSTS -- HEALTH TEAM (2 YEARS)

(\$000)

	YEAR 1 TOTAL	YEAR 2 TOTAL	TWO YEAR TOTAL
I. SALARY COSTS			
A. US/EUR. PERSONNEL *			
PROFESSIONAL	96	100	196
NON-PROFESSIONAL	36	38	74
FIELD STAFF-PROF.-LONG TERM	396	416	812
FIELD STAFF-NON-PROF.-LONG TERM	18	19	37
SUBTOTAL US/EUR. SALARIES	546	573	1119
B. THIRD COUNTRY NATIONALS OR * COOP. COUNTRY PERSONNEL			
FIELD STAFF-PROFESSIONAL	126	137	263
FIELD STAFF-NON-PROFESSIONAL	60	63	123
SUBTOTAL TCN/COOP SALARIES	186	200	386
III. CONSULTANTS *			
SUBTOTAL CONSULTANTS	64	67	131
III. TRAVEL AND TRANSPORT			
TO-FROM POST	15	16	31
TDY	40	41	81
R&R	15	15	30
HOME LEAVE(not included)	0	0	0
TRANSPORT BELONGINGS & VEHICLES	85	90	175
PER DIEM-INTERNATIONAL	10	10	20
PER DIEM-LOCAL	20	20	40
SUBTOTAL T&T	185	192	377

* includes indirect cost factor

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	YEAR 1 TOTAL	YEAR 2 TOTAL	TWO YEA TOTAL
IV. ALLOWANCES			
OST DIFF	60	62	122
SUNDAY DIFF	9	9	18
QUARTERS	50	55	105
EMP LODGING	8	7	15
EDUCATION INCL. ED TRAVEL	25	25	50
SUBTOTAL ALLOWANCES	152	158	310
V. OTHER DIRECT COSTS			
OFFICE RENT	25	28	53
TELEPHONE/TELEX	6	7	13
BA INSURANCE	11	12	23
REPRODUCTION	10	11	21
LANGUAGE TRAINING	12	3	15
MISC.	12	12	24
SUBTOTAL ODC	76	73	149
VI. EQUIPMENT, VEHICLES, MATERIALS, AND SUPPLIES			
TEACHING MATERIALS	15	15	30
OFFICE FURNISHINGS/SUPPLIES	15	5	20
COMPUTERS	25	-	25
COMPUTER SUPPLIES	10	5	15
VEHICLES	60	-	60
VEHICLE MAINTENANCE & POL	12	12	24
MISC. EQUIPMENT	25	5	30
SHIPPING COSTS	10	10	20
SUBTOTAL EQUIPMENT, ETC.	172	52	224
TOTAL WITHOUT CONTINGENCY	1381	1315	2696
CONTINGENCIES @ 10%	138	132	270
TOTAL	1519	1447	2966
SAY			3000