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A.I.D. EVALUATION SUMMARY - PART I

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

IDENTIFICATION DATA		
A. Reporting A.I.D. Unit: O/AID/Rep Mission or AID/W Office <u>Afghanistan</u> (ES# _____)	B. Was Evaluation Scheduled in Current FY Annual Evaluation Plan? Yes <input checked="" type="checkbox"/> Slipped <input type="checkbox"/> Ad Hoc <input type="checkbox"/> Evaluation Plan Submission Date: FY _____ Q _____	C. Evaluation Timing Interim <input checked="" type="checkbox"/> Final <input type="checkbox"/> Ex Post <input type="checkbox"/> Other <input type="checkbox"/>

D. Activity or Activities Evaluated (List the following information for project(s) or program(s) evaluated; if not applicable, list title and date of the evaluation report.)					
Project No.	Project /Program Title	First PROAG or Equivalent (FY)	Most Recent PACD (Mo/Yr)	Planned LOP Cost (000)	Amount Obligated to Date (000)
306-0201	PVO Co-Financing Project	1986	3/1991	35,000	34,950
306-0208	Rural Assistance Project	1988		10,000	10,000

ACTIONS		
E. Action Decisions Approved By Mission or AID/W Office Director Action(s) Required E. Action Decision As a result of this joint evaluation and discussion within the O/AID/Rep, it was decided to combine all PVO activities under one umbrella project, the PVO Support Project, a 32 month project with a \$20 million funding level. This will simplify project management and documentation requirements and accommodate new directions in sectoral programming. One of the recommendations of the evaluation team was to separate rural rehabilitation and agricultural development activities into two separate strategies, the former managed as previously under RAP and the latter by the Agriculture Office. In accepting this recommendation, the O/AID/Rep laid the ground work for separate sectoral strategies for PVO activities within the context of the umbrella project. The case for sectoral strategies was furthered by the existence of a PVO health strategy, which predated the (continued)	Name of Officer Responsible for Action	Date Action to be Completed

APPROVALS			
F. Date Of Mission Or AID/W Office Review Of Evaluation:	(Month)	(Day)	(Year)

G. Approvals of Evaluation Summary And Action Decisions:				
	Project/Program Officer	Representative of Borrower/Grantee	Evaluation Officer	Mission or AID W Office Director
Name (Typed)	T. Eighmy H. Cushin		C. Walters	<i>[Signature]</i>
Signature	<i>[Signature]</i>			
Date	7-11-			

ABSTRACT

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

H. Evaluation Abstract

Based on the evaluation of the two PVO projects, several overall observations can be made regarding A.I.D. support for PVO activities in Afghanistan.

PVOs are particularly effective at implementing technically simple activities that require close contacts with the target population. These activities are making a significant contribution to the objectives of A.I.D.'s cross-border humanitarian assistance program and should continue to be funded. A.I.D./Rep management of the PVO programs, however should be based on the recognition that PVOs have their own objectives and priorities and cannot be depended on to support U.S. government political objectives or A.I.D.'s longer-term development objectives.

The somewhat artificial separation of A.I.D. support to PVOs in two projects serves no useful purpose but also does not create any significant management problems. Regardless of whether there are one or two projects, however it is essential for management purposes that the PVO health, rural rehabilitation, and agricultural development programs be restructured as specific sub projects, each with its own purpose, outputs, and management system.

The management system for the PVO health program should be the model for the PVO programs that raise important policy issues or are closely linked to the A.I.D./Rep sector programs. The main advantage of this system is that it allows easy direct contact between A.I.D./Rep staff and the implementing PVOs. If agricultural development activities eventually become a major PVO program, they should be managed directly by the Agricultural Development Officer using the same system as for the PVO health program. If they are kept small in number, as the evaluation team recommends they will have little impact on A.I.D.'s agricultural sector program and can continue to be managed as a part of the PVO rural rehabilitation program.

COSTS

I. Evaluation Costs

1. Evaluation Team		Contract Number: OR TDY Person Days	Contract Cost OR TDY Cost (U.S. \$)	Source of Funds
Name	Affiliation	Contract No.		
Roger Poulin (team leader)	DAI (IQC)	306-0200-	\$76.758	FY 89 PDS
John McGill, MD	DAI (IQC)	C-00-9987-00		
Richard English, Ph.D.	DAI (IQC)	21 days	\$4.500	FY 90 OE
Sharon Fee	ANE/TR/ARD			

2. Mission/Office Professional Staff Person-Days (Estimate) <u>10</u>	3. Borrower/Grantee Professional Staff Person-Days (Estimate) <u>N/A</u>
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evaluation, and by future plans to develop a strategy to promote democratic pluralism.

To encompass these different sectoral PVO activities in the PVO Support Project, it was decided that the project's general document, the Activity Approval Memorandum (AAM), would define O/AID/Rep's overall objectives in supporting PVOs and also lay out the framework for the development of sectoral and cross-sectoral strategies. These strategies were attached to the AAM as freestanding and separate documents, incorporated by reference, and explain in some detail how the O/AID/Rep would supports PVOs in each selected sector.

With this new project, each sectoral strategy may be amended or updated as the situation requires without having to amend the overall project. Additional strategies may also be added as needed. In this way, the O/AID/Rep will continue to have, as it did with the PVO Co-Financing Project and RAP, a rapid, flexible mechanism through which to respond to the evolving situation inside Afghanistan.

Activities previously funded under the PVO Co-Financing Project and RAP will be carried on respectively through the health and rural assistance strategies, and agricultural development activities will be supported under the agricultural development strategy.

The new PVO Support Project (306-0211) was authorized by the Mission is May 1990.

A.I.D. EVALUATION SUMMARY - PART II

SUMMARY

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

Address the following items:

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

Mission or Office:

Date This Summary Prepared:

Title And Date Of Full Evaluation Report: (Jan. 1990)

O/AID/Rep

July 1990

Evaluation of the Afghanistan PVO Co-Financing and Rural Assistance Projects.

J. Summary of Evaluation Findings, Conclusion and Recommendation

The U.S. Agency for International Development Representative for Afghanistan Affairs (A.I.D./Rep) funds two private voluntary organization (PVO) projects for Afghanistan. The PVO Co-Financing Project was approved in 1986 and funded two major types of activities: "cash-for-food" intended to help destitute people survive areas of heavily affected by the war, and programs to train health care workers to staff in war-affected areas. Both of these activities were evaluated in 1987. In 1988, the cash-for-food activities were split off from the Co-Financing Project and included in a new Rural Assistance Project (RAP). RAP was designed to move PVO activities from survival assistance to rural rehabilitation. Health activities remained in the PVO Co-Financing Project.

The purpose of this evaluation is to update the evaluation of health activities and carry out an initial interim evaluation of RAP. It should be emphasized that the evaluation team was unable to get into Afghanistan. The information of this report was obtained mainly from project files and interviews with the staff of the A.I.D./Rep office and the PVOs implementing activities under these two projects.

The evaluation was undertaken by a team of consultants contracted by Development Alternatives, Inc. (DAI). The members of the team were: Roger Poulin, economist and team leader; John McGill, M.D., former medical director of the Peshawar-based Committee for Medical Coordination; and Richard English, Ph.D., anthropologist and Afghanistan specialist. In addition, Sharon Fee, an A.I.D./Washington Agricultural Development Officer, served as rural development specialist for the team.

After preliminary document review and briefings with a number of home office directors of private voluntary organizations (PVOs) and A.I.D. staff in Washington, D.C., the team spent one month in Islamabad, Peshawar, and Quetta reviewing project files, and consulting with A.I.D./Rep project managers and the staff of the 15 PVO grant recipients. In addition, the team interviewed staff of other PVOs involved in cross-border assistance and the administrators of the A.I.D./Rep funded sectoral support projects in Afghanistan, as well as representatives of the United Nation High Commission for Refugees, the World Health Organization, the United Nations Development Programme, the Commissionerate of Afghan Refugees of the Government of Pakistan, and representatives of the Afghan Interim Government.

A. Rural Assistance Project

Since July 1988, RAP has funded 27 grants totalling \$7.9 million. Of this total, \$5.6 million was for grants to increase agricultural productivity or rural income, and \$2.3 million was for emergency or survival grants. RAP is managed through a cooperative agreement with the International Rescue Committee (IRC). IRC's main responsibilities are to oversee the grant approval process, monitor the implementation of the individual grants, and assure satisfactory reporting to A.I.D./Rep. The team was not able to verify to its satisfaction the impact of the funded activities on the target populations, mainly because of the little

independent monitoring to confirm the information received from the implementing PVOs. However, on the basis of documentation available to the team and discussions with implementing PVOs and other organizations in Peshawar and Quetta, the team concludes that the RAP-funded activities achieved most of their stated objectives.

The main issue related to RAP implementation and achievement of objectives are:

1. The role of PVOs in rural rehabilitation and increasing agricultural productivity in Afghanistan.

The issue here is whether PVOs should be used to channel assistance to Afghanistan until they are no longer needed. Do they have particular strengths that complement those of A.I.D. contractors and other possible implementors of assistance activities in Afghanistan? The evaluation found that the particular strengths of PVOs are their contacts inside Afghanistan, their low operating costs, and their relative effectiveness in implementing simple relief activities. As activities became more complex, PVOs became hampered by their limited management capacity and their lack of technical and development expertise.

2. The type of monitoring that is appropriate for this type of project under conditions that prevail in Afghanistan

The essential information required by management is whether the activities funded by RAP grants were implemented as planned and achieved and achieved their intended objectives. Obtaining this information has proven extremely difficult. First, A.I.D./Rep staff cannot enter Afghanistan. Second, reports from RAP grantees describe activities and account for RAP funds, but contain little information about implementation problems and ways in which funds might have been misspent. Finally, there is no independent monitoring to verify that the PVO reports are accurate. The end result is that, in the opinion of the evaluation team, A.I.D./Rep is unable to determine whether RAP grants were spent as planned, much less whether they achieved their intended objectives. There is an urgent need to develop a monitoring and evaluation methodology to be used by RAP grantees that addresses both implementation and impact. Also, until Americans can enter Afghanistan, A.I.D./Rep needs to set up an effective independent monitoring capacity. This capacity should be in the International Rescue committee/RAP management unit (IRC/RAP) as provided for in the existing cooperative agreement.

3. Appropriate verifiable indicators of success to be used in the management of this project

RAP was designed to fund activities identified and implemented by PVOs as a part of their own programs. As such, the key measurable indicator of project success is not only for this type of project, but also because of the difficult conditions currently prevailing in Afghanistan. However, the key measure of project success at the overall project level is whether agricultural productivity and rural incomes have been increased as a result of the project. This requires that A.I.D./Rep have some indication of the critical constraints. The evaluation, therefore, recommends that A.I.D./Rep set purpose-level targets and priorities based on an assessment of what are the most critical constraints in the different regions of Afghanistan, and A.I.D./Rep use these targets and priorities to select activities for funding and measure project success. This implies more substantive management at the overall project level by IRC/RAP or the A.I.D./Rep Office -- a management that understands the technical aspects of projects as well as the administrative concerns.

4. The management structure

The present structure follows the provisions of the cooperative agreement with IRC. The strengths of this arrangement are that the IRC/RAP management unit reduces the administrative burden on A.I.D./Rep and the approval process is expedited by being based in Peshawar. The major flaw is that IRC, which is the only organization in close direct contact with RAP grantees, does not have the capability to provide technical management of the project. The result is a cumbersome management system, with PVOs forced to bypass IRC/RAP and deal directly with A.I.D./Rep to obtain answers to substantive questions.

The evaluation team recommends that either IRC/RAP be given responsibility for the substantive review of proposals and be provided with the necessary technical staff to perform this function, or the cooperative agreement be terminated, and a management unit be established in RAO/Peshawar to assume substantive management as well as perform IRC/RAP administrative and monitoring responsibilities.

B. The PVO Co-Financing Project

When this project was last evaluated, most of the health activities were just getting underway. These programs have been operating for three years. They have trained over 500 health care providers, and are supporting close to one hundred clinics in Afghanistan. In FY 1989, A.I.D. provided \$7 million for the continuation of these ongoing activities.

In the absence of epidemiological data, the health impact of the project on the population being served cannot be measured. The most easily measured indicator of project success is the number of health care providers produced and the quality of their training. The number of trainees is no longer a positive factor, since there are substantially more clinics in Afghanistan today than before the war. The evaluation team found that the quality of training has improved steadily since the start of the project. If those trained three years ago were to return today, they would think they were taking a completely different course.

The steps needed at this time to improve project performance and impact in Afghanistan are:

1. Improved monitoring should aim at measuring the quality of health care being provided.

Most of the monitoring to date has been limited to verifying that clinics are operating. These efforts are providing enough useful information for PVOs to identify major problems and take corrective action, sometimes involving the closing of poorly or non-functioning clinics. Assessing quality has proven to be more difficult. The PVOs seem to be settling on using debriefings of returning health care providers as the most cost-effective means of assessing the quality of care being provided inside. The evaluation team concurs with this approach. However, independent expatriate medical monitoring is the most reliable and valid means of evaluating the quality and impact of health services delivered in Afghanistan. A.I.D./Rep should actively encourage and support this type of monitoring. It should receive all major monitoring reports and understand the findings and their implications.

The monitoring issues mentioned above for RAP also apply to the health activities. A.I.D./Rep management of these activities is seriously hampered by its inability to verify PVO performance and impact inside Afghanistan. Until U.S. government employees are allowed to enter Afghanistan, an alternative means of verification will be needed. At present, it appears that the U.S. Agency for International Development (USAID) is in the best position to

2. Training programs should concentrate on upgrading the quality of health care of providers already trained and working in Afghanistan.

One PVO, Freedom Medicine, has shifted its training program completely to retraining, and another, Mercy Corps International, is retraining the health care providers it is supporting in Afghanistan by having them take the full eight-month MCI course. The evaluation team recommends a general policy of no new health care providers, and a restructuring of existing training programs as retraining programs. The major focus should be to prepare a proper curriculum for these retraining courses drawing heavily on Freedom Medicine's experiences.

3. In order to facilitate the eventual integration of PVO supported clinics into a national health system, the health PVOs should increase their efforts at standardization.

The PVOs have made considerable progress in this area including standard drug lists, a standard text for diagnosis and treatment of common diseases, a standard monitoring questionnaire, and relatively equitable salaries. Recently, a minimum skills list for low-, middle-, and upper-level health care providers has been developed. The next step is for the skills list to be transformed into certification exams for the difference levels of health provider. Also, an optimum clinic composition -- in terms of personnel, physical plant, and equipment -- should be developed. One problem is that, because standardization is voluntary, it can take some time before these standards are fully adopted by all organizations.

Lessons Learned

First, PVOs are particularly effective at implementing technically simple activities that require close contacts with the target population. These activities are making a significant contribution to the objectives of A.I.D.'s cross-border humanitarian assistance program and should continue to be funded. A.I.D./REP management of the PVO programs, however, should be based on the recognition that PVOs have their own objectives and priorities and cannot be depended on to support U.S. government political objectives of A.I.D.'s longer-term development objectives.

Second, the somewhat artificial separation of A.I.D. support to PVOs into two projects serves no useful purpose but also does not create any significant management problems. Regardless of whether there are one or two projects, however, it is essential for management purposes that the PVO health, rural rehabilitation, and agricultural development programs be restructured as specific subprojects, each with its own purpose, outputs, and management system.

Third, the management system for the PVO health program should be the model for the PVO programs that raise important policy issues or are closely linked to the A.I.D./REP sector programs. The main advantage of this system is that it allows easy direct contact between A.I.D./REP staff and the implementing PVOs. If agricultural development activities eventually become a major PVO program, they should be managed directly by the Agricultural Development Officer using the same system as for the PVO health program. If they are kept small in number, as the evaluation team recommends, they will have little impact on A.I.D.'s agricultural sector program and can continue to be managed as part of the PVO rural rehabilitation program.

ATTACHMENTS

K. Attachments (List attachments submitted with this Evaluation Summary, always attach copy of full evaluation report, even if one was submitted earlier; attach studies, surveys, etc., from "on-going" evaluation, if relevant to the evaluation report.)

1. Scope of Work
2. Evaluation
3. Mission Comments on draft evaluation
4. PVO/grantees' comments on draft evaluation
5. Mission comments on final evaluation

COMMENTS

L. Comments By Mission, AID/W Office and Borrower/Grantee On Full Report

(see attached)

- A. Mission's comments on final draft
- B. PVO/grantees' comments on final draft
- C. Mission comments on final evaluation

XD-ABB-829-A

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**Evaluation of
the Afghanistan
PVO Co-Financing
and Rural
Assistance
Projects**

Prepared for the U.S. Agency for International Development under contract
number 306-0200-C-00-9987-00

Roger Boulton
Richard English
Sharon Fee
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90
January 1990

DAI

Development Alternatives, Inc. 624 N. ... Washington, D.C. 20001

9

PREFACE

The following report is a joint evaluation of the PVO Co-Financing and Rural Assistance Projects funded by the Office of the U.S. Agency for International Development Representative for Afghanistan Affairs (A.I.D./Rep). Both projects are important components of A.I.D./Rep's program of cross-border humanitarian assistance to war-affected Afghans.

The evaluation was undertaken by a team of consultants contracted by Development Alternatives, Inc. (DAI). The members of the team were: Roger Poulin, economist and team leader; John McGill, M.D. and former medical director of the Peshawar-based Committee for Medical Coordination; and Richard English, anthropologist and Afghanistan specialist. In addition, Sharon Fee, an A.I.D./Washington Agricultural Development Officer, served as rural development specialist for the team.

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This evaluation is organized into three parts: Part One presents the team's findings and recommendations concerning the Rural Assistance Project (RAP); Part Two presents the team's findings and recommendations on the PVO Co-Financing Project; and Part Three presents findings and conclusions on cross-sectoral A.I.D. support for PVO activities in Afghanistan.

The team would like to express its thanks to the many staff members of the office of the A.I.D./Rep in Islamabad and its Regional Affairs Office in Peshawar for their support during this evaluation. In addition, the team would like to thank the staff of all the PVOs supported by the Co-Financing and RAP Projects, as well as the staff of the International Rescue Committee/RAP, for their cooperation during the team's investigations. We share with them the hope that peace will come soon to the people of Afghanistan.

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ACRONYMS

Activity Approval Memorandum
 Office of the A.I.D. Representative for Afghanistan Affairs
 Agency Coordinating Body for Afghan Relief
 Agricultural Development Officer
 Agence Internationale Contre le Faim
 Amitié Franco-Afghan
 Afghanistan Interim Government
 Basic Health Worker
 Coordination of Humanitarian Assistance
 Coordination of Medical Committees
 German Afghanistan Committee
 Food and Agriculture Organization
 Health Unlimited
 Italian Cooperation for Development
 International Medical Corps
 International Rescue Committee
 The management unit of IRC's RAP program
 Mercy Corps International
 Medecins du Monde
 Ministry of Public Health, Afghan Interim Government
 Medical Refresher Course for Afghans
 Management Sciences for Health
 Medical Training for Afghans
 Personal services contract
 Private voluntary organization
 Regional Affairs Office of A.I.D./Rep in Peshawar
 Rural Assistance Project
 South West Afghanistan and Baluchistan Agency Coordination
 Swedish Committee for Afghanistan
 Save the Children Federation
 United Nations International Children's Fund
 United Nations Office of the Coordinator for Afghanistan
 United Nations High Commissioner for Refugees
 Volunteers in Technical Assistance
 World Health Organization

EXECUTIVE SUMMARY

The U.S. Agency for International Development Representative for Afghanistan Affairs (A.I.D./Rep) funds two private voluntary organization (PVO) projects for Afghanistan. The PVO Co-Financing Project was approved in 1986 and funded two major types of activities: "cash-for-food" intended to help destitute people survive in areas heavily affected by the war, and programs to train health care workers to staff clinics in war-affected areas. Both of these activities were evaluated in 1987. In 1988, the cash-for-food activities were split off from the Co-Financing Project and included in a new Rural Assistance Project (RAP).¹ RAP was designed to move PVO activities from survival assistance to rural rehabilitation. Health activities remained in the PVO Co-Financing Project.

The purpose of this evaluation is to update the evaluation of health activities and carry out an initial interim evaluation of RAP. It should be emphasized that the evaluation team was unable to go into Afghanistan. The information for this report was obtained mainly from project files and interviews with the staff of the A.I.D./Rep office and the PVOs implementing activities under these two projects.

The Rural Assistance Project

Since July 1988, RAP has funded 27 grants totalling \$7.9 million. Of this total, \$5.6 million was for grants to increase agricultural productivity or rural incomes, and \$2.3 million was for emergency or survival grants. RAP is managed through a cooperative agreement with the International Rescue Committee (IRC). IRC's main responsibilities are to oversee the grant approval process, monitor the implementation of the individual grants, and assure satisfactory reporting to A.I.D./Rep. The team was not able to verify to its satisfaction the impact of RAP-funded activities on the target populations, mainly because there was little independent monitoring to confirm the information received from the implementing PVOs. However, on the basis of documentation available to the team and discussions with implementing PVOs and other organizations in Peshawar and Quetta, the team concludes that the RAP-funded activities achieved most of their stated objectives.

The main issues related to RAP implementation and achievement of objectives are:

1. **The role of PVOs in rural rehabilitation and increasing agricultural productivity in Afghanistan**

The issue here is whether PVOs should be used to channel assistance to Afghanistan until they are no longer needed. Do they have particular strengths that complement those of A.I.D. contractors and other possible implementors of assistance activities in Afghanistan? The evaluation found that the particular strengths of PVOs are their contacts inside Afghanistan, their low operating costs, and their relative effectiveness in implementing simple relief activities. As activities become more complex, PVOs become hampered by their limited management capacity and their lack of technical and development expertise.

¹ The acronym RAP is used to refer specifically to the Rural Assistance Project funded by A.I.D./Rep, while IRC RAP (International Rescue Committee/Rural Assistance Project) is used to refer to the management unit of the project located in Peshawar.

PVO staff and local contacts are particularly well suited to implement simple, local self-help activities. Most of the activities currently being funded by RAP (for example, repair of irrigation systems and rural roads) are of this type. However, most RAP grantees do not currently have the technical expertise and development experience to implement complex construction projects or agricultural projects with development objectives. For these reasons, the evaluation team recommends that PVOs continue to be funded primarily for simple relief and rural rehabilitation activities. RAP should fund complex construction and agricultural development activities only under exceptional circumstances and after careful review by the Agricultural Development Office.

2. The type of monitoring that is appropriate for this type of project under conditions that prevail in Afghanistan

The essential information required by management is whether the activities funded by RAP grants were implemented as planned and achieved their intended objectives. Obtaining this information has proven extremely difficult. First, A.I.D./Rep staff cannot enter Afghanistan. Second, reports from RAP grantees describe activities and account for RAP funds, but contain little information about implementation problems and ways in which funds might have been misspent. Finally, there is no independent monitoring to verify that the PVO reports are accurate. The end result is that, in the opinion of the evaluation team, A.I.D./Rep is unable to determine whether RAP grants were spent as planned, much less whether they achieved their intended objectives. There is an urgent need to develop a monitoring and evaluation methodology to be used by RAP grantees that addresses both implementation and impact. Also, until Americans can enter Afghanistan, A.I.D./Rep needs to set up an effective independent monitoring capacity. This capacity should be in the International Rescue Committee/RAP management unit (IRC/RAP) as provided for in the existing cooperative agreement.

3. Appropriate verifiable indicators of success to be used in the management of this project

RAP was designed to fund activities identified and implemented by PVOs as part of their own programs. As such, the key measurable indicator of project success is the successful completion of the individual RAP-funded activities. This is appropriate, not only for this type of project, but also because of the difficult conditions currently prevailing in Afghanistan. However, the key measure of project success at the overall project level is whether agricultural productivity and rural incomes have been increased as a result of the project. This requires that A.I.D./Rep have some indication of the critical constraints to increasing agricultural productivity and rural incomes in Afghanistan and have some way of assessing whether project activities have addressed these constraints. The evaluation, therefore, recommends that A.I.D./Rep set purpose-level targets and priorities based on an assessment of what are the most critical constraints in the different regions of Afghanistan, and A.I.D./Rep use these targets and priorities to select activities for funding and measure project success. This implies more substantive management at the overall project level by IRC/RAP or the A.I.D./Rep Office -- a management that understands the technical aspects of projects as well as the administrative concerns.

4. The management structure

The present structure follows the provisions of the cooperative agreement with IRC. The strengths of this arrangement are that the IRC/RAP management unit reduces the administrative burden on A.I.D./Rep and the approval process is expedited by being

based in Peshawar. The major flaw is that IRC, which is the only organization in close direct contact with RAP grantees, does not have the capability to provide technical management of the project. The result is a cumbersome management system, with PVOs forced to bypass IRC/RAP and deal directly with A.I.D./Rep to obtain answers to substantive questions.

The evaluation team recommends that either IRC/RAP be given responsibility for the substantive review of proposals and be provided with the necessary technical staff to perform this function, or the cooperative agreement be terminated, and a management unit be established in RAO/Peshawar to assume substantive management as well as perform IRC/RAP administrative and monitoring responsibilities.

The PVO Co-Financing Project

When this project was last evaluated, most of the health activities were just getting underway. These programs have been operating for three years. They have trained over 500 health care providers, and are supporting close to one hundred clinics in Afghanistan. In FY 1989, A.I.D. provided \$7 million for the continuation of these ongoing activities.

In the absence of epidemiological data, the health impact of the project on the population being served cannot be measured. The most easily measured indicator of project success is the number of health care providers produced and the quality of their training. The number of trainees is no longer a positive factor, since there are substantially more clinics in Afghanistan today than before the war. The evaluation team found that the quality of training has improved steadily since the start of the project. If those trained three years ago were to return today, they would think they were taking a completely different course.

The steps needed at this time to improve project performance and impact in Afghanistan are:

1. **Improved monitoring should aim at measuring the quality of health care being provided.**

Most of the monitoring to date has been limited to verifying that clinics are operating. These efforts are providing enough useful information for PVOs to identify major problems and take corrective action, sometimes involving the closing of poorly or non-functioning clinics. Assessing quality has proven to be more difficult. The PVOs seem to be settling on using debriefings of returning health care providers as the most cost-effective means of assessing the quality of care being provided inside. The evaluation team concurs with this approach. However, independent expatriate medical monitoring is the most reliable and valid means of evaluating the quality and impact of health services delivered in Afghanistan. A.I.D./Rep should actively encourage and support this type of monitoring. It should receive all major monitoring reports and understand the findings and their implications.

The monitoring issues mentioned above for RAP also apply to the health activities. A.I.D./Rep management of these activities is seriously hampered by its inability to verify PVO performance and impact inside Afghanistan. Until U.S. government employees are allowed to enter Afghanistan, an alternative means of independent verification will be needed. At present, it appears that the Coordination of Medical Committees (CMC) is in the best position to perform this function.

2. **Training programs should concentrate on upgrading the quality of health care of providers already trained and working in Afghanistan.**

One PVO, Freedom Medicine, has shifted its training program completely to retraining, and another, Mercy Corps International, is retraining the health care providers it is supporting in Afghanistan by having them take the full eight-month MCI course. The evaluation team recommends a general policy of no new health care providers, and a restructuring of existing training programs as retraining programs. The major focus should be to prepare a proper curriculum for these retraining courses drawing heavily on Freedom Medicine's experience.

3. **In order to facilitate the eventual integration of PVO-supported clinics into a national health system, the health PVOs should increase their efforts at standardization.**

The PVOs have made considerable progress in this area including standard drug lists, a standard text for the diagnosis and treatment of common diseases, a standard monitoring questionnaire, and relatively equitable salaries. Recently, a minimum skills list for low-, middle-, and upper-level health care providers has been developed. The next step is for the skills list to be transformed into certification exams for the difference levels of health provider. Also, an optimum clinic composition -- in terms of personnel, physical plant, and equipment -- should be developed. One problem is that, because standardization is voluntary, it can take some time before these standards are fully adopted by all organizations.

Overall A.I.D./Rep Support for PVO Activities

Based on the evaluation of the two PVO projects, several overall observations can be made regarding A.I.D. support for PVO activities in Afghanistan.

First, PVOs are particularly effective at implementing technically simple activities that require close contacts with the target population. These activities are making a significant contribution to the objectives of A.I.D.'s cross-border humanitarian assistance program and should continue to be funded. A.I.D./Rep management of the PVO programs, however, should be based on the recognition that PVOs have their own objectives and priorities and cannot be depended on to support U.S. government political objectives or A.I.D.'s longer-term development objectives.

Second, the somewhat artificial separation of A.I.D. support to PVOs into two projects serves no useful purpose but also does not create any significant management problems. Regardless of whether there are one or two projects, however, it is essential for management purposes that the PVO health, rural rehabilitation, and agricultural development programs be restructured as specific subprojects, each with its own purpose, outputs, and management system.

Third, the management system for the PVO health program should be the model for the PVO programs that raise important policy issues or are closely linked to the A.I.D./Rep sector programs. The main advantage of this system is that it allows easy direct contact between A.I.D./Rep staff and the implementing PVOs. If agricultural development activities eventually become a major PVO program, they should be managed directly by the Agricultural Development Officer using the same system as for the PVO health program. If they are kept small in number, as the evaluation team recommends, they will have little impact on A.I.D.'s agricultural sector program and can continue to be managed as part of the PVO rural rehabilitation program.

PART ONE
THE RURAL ASSISTANCE PROJECT

BACKGROUND

BACKGROUND

Since the Soviet invasion of Afghanistan in December 1979, an increasing number of private voluntary organizations (PVOs) have established themselves in the Pakistan border towns of Peshawar and Quetta to provide humanitarian assistance to the civilian population of the country. The majority of these PVOs have directed their activities to the needs of the enormous population of Afghan refugees that settled in the districts of western Pakistan. However, a small number of American and European PVOs have devoted themselves to providing medical assistance and food relief directly to populations in Afghanistan.

In the spring of 1985, the U.S. government developed a strategy for providing cross-border humanitarian assistance from Pakistan to war-affected populations in Afghanistan. Major components of this strategy were health, education and cash-for-food (CFF) activities implemented by selected European PVOs. Under the CFF component, cash grants were distributed directly to beneficiaries in an effort to both relieve their suffering and provide them with an alternative to joining the ranks of the internally displaced or the refugees settled in Pakistan. Eight million dollars were provided for these activities from the Office of Foreign Disaster Assistance (OFDA) and Asia Bureau regional funds. Because a number of the European PVOs were unwilling to accept direct U.S. funding, the U.S.-based International Rescue Committee (IRC) and the AmeriCares Foundation agreed to act as intermediaries through which funds could be passed to selected PVOs.

In August 1986, this Washington-based PVO program was replaced by a five-year, multi-sectoral cross-border humanitarian assistance program entitled the PVO Co-Financing Project administered by the office of the U.S. Agency for International Development Representative for Afghanistan Affairs (A.I.D./Rep) in Islamabad. IRC and AmeriCares retained their role as intermediary grantors of project funds. Approximately 50 percent of the project funds supported health-related activities, especially medical training. An education and two agricultural programs were also supported. In addition, financial assistance was provided to support a cash-for-food program and a resettlement grant for internally displaced refugees. In April 1987, A.I.D. authorized an increase of the PVO Co-Financing Project budget to \$35 million.

In a subsequent effort to move away from strictly cash relief grants, the office of the A.I.D./Rep proposed the creation of a Rural Assistance Project (RAP) that would be funded independently of the health activities supported by the PVO Co-Financing Project.¹ The goal of the RAP was to provide assistance to war-affected Afghans who wish to remain in, or return to, their home villages and towns. The designers of the project sought to encourage a gradual replacement of cash-for-food disbursements with activities designed to promote the increase of agricultural productivity and rural incomes in Afghanistan, and to facilitate the provision of food and other subsistence-related commodities in stabilized Afghan communities.

In June 1988, A.I.D. signed a two-year cooperative agreement with IRC for \$9.4 million. This agreement authorized IRC to provide and administer grants to PVOs for the support of rural assistance activities inside Afghanistan. Under this agreement, four types of grants were authorized:

¹ Throughout the report, the acronym RAP is used to refer specifically to the Rural Assistance Project funded by A.I.D./Rep, while IRC/RAP (International Rescue Committee/Rural Assistance Project) is used to refer to the management unit of the project located in Peshawar.

SECTION ONE
PROJECT IMPLEMENTATION

INTRODUCTION

Thus far, 27 grants totalling about \$7.9 million have been made to PVOs under the RAP. Of these, nine have been completed and the remainder are scheduled to be completed by April 1990. The breakdown of the subgrants by PVO and by category of activity are presented in tables 1 and 2.

TABLE 1
RAP GRANTS BY PVO

	<u>No. of Grants</u>	<u>Amount (\$mill.)</u>
Afghanaid	8	2.2
AFRANE	6	1.4
CARE	1	1.0
MCI	2	.2
Mercy Fund	3	.5
SCF	5	1.5
Solidarité	1	.8
CHA	1	.3
Total	27	7.9

TABLE 2
RAP GRANTS BY CATEGORY

	<u>No. of Grants</u>	<u>Amount (\$mill.)</u>
Survival Grants	7	1.9
Emergency Grants	6	.4
Village Assistance	19	5.6
Settlement Grants	-	-
Total	32*	7.9

* Includes double counting because some of the grants included more than one category.

The majority of village assistance grants to date have been for elementary rural infrastructure rehabilitation and input distribution. The purposes for which these funds are used include:

- The provision of agricultural inputs, including wheat seed, vegetable seeds, hand tools, and fertilizer.
- The repair and cleaning of irrigation infrastructure including *karez* (irrigation systems) in the south, and primary and secondary irrigation canals in several areas of the country.
- The provision of farm-power inputs including oxen, tractors, and threshers.
- The establishment of test, demonstration, and multiplication plots for wheat varieties purchased in Pakistan and donated by the Food and Agriculture Organization (FAO).
- The construction of check dams and reservoirs for water catchment.
- The repair of roads and tracks.

Using funding sources other than A.I.D., PVOs have also been involved in the purchase and distribution of pesticides, animal vaccination programs, and seedling distribution programs.

PVO PERFORMANCE

All of the PVOs receiving RAP funds, except CARE and CHA, a new Afghan PVO, operated relief programs in Afghanistan before the start of the project. The selection of activities that PVOs propose to RAP is based on requests their personnel receive from contacts made during the course of previous relief activities. Once a request from an Afghan group is received, if possible, the PVO sends a team into the area to verify the need and the appropriateness of the activity. If not, the PVO attempts to confirm the information received from independent sources in the Peshawar area. The PVOs also attempt to determine whether other similar activities are ongoing in the area, but will not necessarily reach formal agreement with others regarding issues such as overlap and duplication. Coordination is achieved through active participation in the regional and sectoral subcommittees of the Agency Coordinating Body for Afghan Relief (ACBAR) and Southwest Afghanistan and Baluchistan Agency Coordination (SWABAC) as well as through frequent direct discussions with other PVOs. In preparing the proposals, PVOs obtain technical advice outside of their organization when necessary. Volunteers in Technical Assistance (VITA), the agriculture and rural works sector support contractor for A.I.D./Rep in Afghanistan, is a frequent source of advice for agricultural and irrigation rehabilitation activities.

The main sources of information on the performance of the RAP subgrantees in the implementation of the subgrants were: (1) interviews with their Peshawar-based staff and field staff if they were in Peshawar; (2) project reports; and (3) interviews with individuals who had first-hand knowledge of how certain RAP-funded projects were being implemented. It must be emphasized that the evaluation team and A.I.D./Rep feel that most of this information cannot be verified without visiting the project sites. This is because there is little reliable independent in-country monitoring that can confirm the information received by the team in Peshawar. It was not unusual for team members to receive directly contradictory information and assessments of RAP-funded activities from supposedly informed sources.

With this important caveat, the following summarizes our findings regarding the performance and implementation capacity of the individual PVOs. Additional details are presented in Annex A.

Solidarité Afghanistan is primarily a relief organization. It has received one grant from RAP for \$800,000. These funds were disbursed by teams going into Afghanistan, often to very remote places, for periods averaging two months. The funds were used for cash-for-food and cash-for-work activities, and for the distribution of agricultural tools and inputs. Expatriates participate in these missions and it is our impression that the funds are used effectively to meet critical survival needs. At the present time it does not appear that Solidarité has the capacity to implement multi-year, technically complex activities that require an extended presence in the project area.

Afghanaid is also primarily a relief organization, although recently it has started implementing rehabilitation projects. It has received eight grants from RAP totalling \$2.2 million. Two of these were emergency grants and two were survival grants. The other four were for irrigation rehabilitation and agricultural input distribution. Half of all Afghanaid's RAP funds have been allocated to activities in the Panjshir Valley under the command of Ahmed Shah Massoud. Afghanaid regards Massoud as a reliable and effective counterpart in the identification and implementation of its projects.

It is the team's impression that Afghanaid has a well-organized operation in Peshawar and that it has built up a valuable base of experience for working inside Afghanistan. It has also recruited a professional Afghan staff to design and implement simple rehabilitation and agricultural projects. Its decision to move away from technically complex projects indicates a desire not to move into activities that it is not qualified to implement. Given the organization's lack of experience in construction and agricultural development, Afghanaid proposals for more than simple rehabilitation projects should be carefully reviewed by A.I.D./Rep to assure proper design and adequate implementation capacity on the part of Afghanaid.

AFRANE started as a relief organization working inside Afghanistan, but its RAP-funded activities have all been simple irrigation rehabilitation and agricultural input distribution. Field staff charged with implementing each subgrant include Afghan agriculturalists and civil engineers who work under the periodic supervision of an expatriate agronomist and Afghan project manager based in Peshawar. AFRANE also has a full-time expatriate supervisor for its projects in Kandahar.

It should be noted that the Regional Affairs Office (RAO) engineer found recent AFRANE proposals lacked technical content and asked that implementation reporting contain detailed information on the progress, nature, and cost of construction activities. Since the activities are just getting underway, the team was unable to determine whether AFRANE will be able to meet these reporting requirements. As in the case of Afghanaid, the team recommends that AFRANE demonstrate to the satisfaction of A.I.D./Rep agricultural and engineering staff the necessary design and implementation capacity before being funded for activities that include major construction or agricultural components.

Mercy Fund started working in Afghanistan as a relief and health organization. Its first two RAP grants were for emergency assistance associated with the siege of Jalalabad in April 1988. Contacts established at that time led to a request for assistance in the rehabilitation of the Ghaziabad state farms for olive production. The grant was for simple rehabilitation activities, but the longer-term objective is the return to prewar production levels. Before undertaking this activity, Mercy Fund consulted numerous experts in the production and marketing of olives. It has recently submitted a proposal for a grant to continue the rehabilitation of the farm. Since Mercy Fund has little experience in agricultural development, its capacity to design and implement such projects should be carefully analyzed by A.I.D./Rep before funding this follow-on grant.

Save the Children (SCF) and Mercy Corps International (MCI) both have a strong interest in income generating development projects rather than simple relief and rehabilitation projects. They are actively identifying viable development projects and are seeking funds from RAP as well as other sources, especially U.N. agencies. Both organizations have expatriate and Afghan agricultural staff. Also, both organizations, especially Save the Children, have had experience implementing community-based development projects in other parts of the world. Although they could submit proposals for simple rehabilitation projects it is more likely that they will submit proposals that have longer-term development objectives.

The CARE and CHA grants have only recently been approved so there is little to say about their implementation. The CARE grant is for a food-for-work project, an activity for which the organization is eminently qualified. CHA, a new Afghan PVO, is at the other extreme. It has never implemented relief or rehabilitation projects but does have the advantage of knowing Afghanistan. Its proposed project is in a very difficult area of Afghanistan (Farah) and will be implemented by professional staff from the area. IRC/RAP and A.I.D./Rep will have to follow this activity closely to assure that project objectives are achieved and that continued funding for CHA activities is justified.

A major issue related to the implementation of RAP activities is monitoring by the PVOs. In general, PVOs have not yet found a way to document conclusively that their projects have been implemented as planned and that the desired impact was achieved. Perhaps the most satisfactory internal monitoring is achieved by Solidarité, which usually sends an expatriate with each mission to stay until the activity is completed. Yet, even in this case there is no basis for outside evaluators to verify the accuracy of Solidarité records. Most PVOs seem to be putting increasing efforts in monitoring, but for years their programs were based on the trust and respect that they have for the commanders and shuras with whom they work. For many PVOs, these relationships continue to be a substitute for onerous and costly evaluations that may or may not produce information that will improve project implementation and increase project impact.

Two specific areas of PVO performance of particular concern to the A.I.D./Rep Office are relationships between headquarters and field offices and the degree of active Afghan involvement in PVO activities. In the detailed discussion of each PVO program in Annex A, it will be noted that all of the RAP grantees have considerable autonomy in the choice and implementation of activities in Afghanistan. Similarly, the evaluation team observed that all of the grantees have Afghan technical staff who are in supervisory positions either in Peshawar and Quetta or in the field. These individuals are making important substantive contributions to the PVO programs being financed under RAP.

IRC PERFORMANCE

Findings

The cooperative agreement between A.I.D./Rep and IRC required that IRC assume the management and oversight of subgrant activities. This section reviews the major responsibilities accepted by IRC under the terms of the agreement and how well they were carried out.

1. Set up a system for the preparation, review, and approval of grant proposals, including the establishment of selection criteria, and develop guidelines for the preparation of proposals and a format for proposals.

IRC carried out this task within the deadlines set in the cooperative agreement in close cooperation with RAO/Peshawar. Inputs from the RAO project manager were particularly useful in preparing the selection criteria. As the project manager noted at the time, it was unrealistic to expect that criteria prepared within 15 days of signing the agreement would satisfactorily deal with all design and implementation issues related to this project.

There is now general agreement among A.I.D./Rep, IRC, and the PVOs that the selection criteria should be clarified and the proposal guidelines and format simplified. With respect to the selection criteria, the need is to move from the existing general guidelines to guidelines that are specific to each category of grant. The PVOs should be provided with specific criteria that will be used to evaluate their requests for emergency grants, survival grants, and village assistance grants. Each of these categories has a different objective, and this should be reflected in the guidelines. As the designer and funder of the project, A.I.D./Rep, rather than IRC, should have the major input in developing these criteria. IRC would then be responsible for applying them in the review and approval of PVO proposals. The evaluation team has prepared suggested selection criteria based on what it understands to be the objectives of this project and A.I.D./Rep's major development policy concerns. (See Annex B.)

Although there is no specific evidence on this matter, it appears that A.I.D./Rep is not encouraging IRC to seek additional PVOs to receive RAP funding. This is despite the fact that \$1.9 million remains available for grants under RAP; if the CARE project had not been funded by RAP, there would be \$2.9 million available. One issue here is whether it is advisable to fund PVOs not registered with A.I.D. Project records indicate that nonregistered PVOs create financial accountability problems for A.I.D. The team feels that the RAP eligibility criteria requiring detailed financial information from these PVOs are sufficient to assure that recipients of RAP funds are financially sound and will be accountable for RAP expenditures.

The proposal guidelines and format have, in general, proven to be well suited to the needs of the project. They can, however, be improved in several respects:

- The guidelines should have more detailed instructions regarding the technical information required for activities that have construction or agricultural components. These would be incorporated into items six, seven, and eight of the proposal guidelines.
- Items 13 to 18 in the proposal preparation guidelines are really selection criteria. Removing them would help clarify the guidelines for the PVOs.
- The proposal format can be simplified and made more useful by relating the format headings to the proposal guidelines. For example, Part F of the format is the most important part of the proposal. The information in this section determines whether the activity is well designed, cost effective, and implementable. The PVO should be able to refer easily to the guidelines to determine the minimum information requirements for this section. As part of the revision exercise, IRC should standardize the RAP format as much as possible with those of other donors, especially the U.N. agencies.

Despite the best efforts of IRC/RAP and RAO P, the approval process is taking longer than expected. The review process in A.I.D. Rep usually takes several weeks. This is due to the number of unanticipated bureaucratic issues that have arisen during the early stages of the project. It now appears that many of these have been resolved and future proposals should require less review time by A.I.D. Rep.

2. Set up a system of quarterly program and financial reports to be submitted by subgrantees to IRC and A.I.D./Rep, and assure the timely submission of reports by subgrantees.

IRC has adopted the standard A.I.D. reporting format that is well suited to this project, and has succeeded in obtaining most quarterly reports on time. The main problem is that, in most cases, the reports provide general information that is not particularly useful for management purposes. As a result, the quarterly reports have not been a useful management tool, or even an effective means of assessing project accomplishments.

3. Review proposals and make recommendations to A.I.D./Rep.

Although IRC had the advantage of having administered part of the PVO Co-Financing Project prior to the start of RAP, its administrative responsibilities are now much more substantial. At first, the IRC/RAP staff lacked the experience needed to substantively review RAP subgrant proposals, especially when the objectives were primarily development rather than relief. This resulted in several early proposals sent on to RAO/Peshawar with key issues not raised or resolved. Through experience and ongoing communications with the A.I.D. project manager, IRC's performance in this regard has improved considerably. Reviews of the last two proposals have been particularly thorough. IRC has also succeeded in steadily improving the quality of proposals received from PVOs.

4. Manage and oversee the project in accordance with the project goal and purposes.

This task implies that IRC was expected to monitor impact and to take corrective actions as appropriate. In retrospect, this turns out to have been an unrealistic request because monitoring impact on beneficiaries is extremely difficult for most projects inside Afghanistan, and IRC/RAP had neither the expertise nor sufficient staff to substantively manage this project. This issue will be discussed further in the section on project design.

5. Monitor the grants through:

- Oral debriefings;
- Review of quarterly and final reports; and
- The establishment of an independent in-country monitoring capacity.

IRC has received oral debriefings from subgrantees and has set up a well-functioning system for receiving timely quarterly reports. However, as noted above, these reports are not particularly useful. The evaluation team has reviewed grantee trip reports and in-house monitoring reports that are much more informative. IRC should regularly receive and review these reports and should take steps to ensure that the PVOs include this information in their quarterly reports.

IRC/RAP's independent monitoring program has not progressed as well as the PVO reporting system. IRC/RAP had hired an expatriate monitor who made useful contributions to the approval process but did not produce useful monitoring reports. Consequently, he was asked to resign. IRC/RAP monitoring teams have monitored a few grants, but the information has not been usable. The problem is that monitoring inside Afghanistan is extremely difficult and requires highly qualified, reliable, and experienced personnel. The teams were not sufficiently experienced and trained to obtain reliable information. The next step for IRC/RAP is to build on these early experiences, improve its evaluation plan for RAP, and hire additional monitoring staff. Adding expatriate, and Afghan if available, technical staff to the RAP unit, although

admittedly costly, will be essential to the success of this effort. The critical need for improved monitoring in the management of this project is discussed in the section on project design issues.

6. Manage the finances of the project including:

- Receiving and disbursing all project funds to grantees;
- Providing accounting advice and oversight to grantees; and
- Receiving quarterly reports from grantees.

Project records indicate that IRC/RAP is performing this task very well. A.I.D./Rep sends a personal services contract (PSC) accountant to review IRC/RAP's and the PVOs' financial records on a regular basis. His reports indicate that RAP expenditures are satisfactorily accounted for. There has been a problem with one PVO (Solidarité Afghanistan) which kept its records in Paris and in French. At the time of this visit, we have been informed that IRC will have received all of the required information in English by the end of November. Several PVOs told the evaluation team that IRC advice was valuable in the improvement of their financial management systems. The one problem that was mentioned by most PVOs is that one week is not enough time to prepare quarterly financial reports. Possibly, the reporting periods could be shifted back by one month so that, for instance, PVO reports in October would cover June-August instead of July-September.

7. Submit regular and ad hoc reports to A.I.D. on project performance and achievement of project objectives.

IRC has submitted all of its reports on time, but, as noted above, these reports have been of limited usefulness because they are based on subgrantee reports that are mostly superficial and not very informative.

Recommendations:

- In order to facilitate the review and approval of subgrants by IRC/RAP, A.I.D./Rep and IRC/RAP should establish specific selection criteria for each category of subgrant. These criteria should be based on the objectives of RAP and the policy and development concerns of A.I.D. in Afghanistan.
- A.I.D./Rep should consider allowing IRC/RAP to encourage additional PVOs to submit proposals for RAP funding.
- IRC/RAP should simplify the proposal preparation guidelines and format as described above.
- IRC/RAP should strengthen its independent monitoring capacity and establish a regular program for in-country monitoring of individual grants as provided for in the cooperative agreement.
- IRC should prepare minimum monitoring, evaluation, and reporting standards for RAP grantees and conduct workshops on evaluation methodology for the grantees..
- A.I.D./Rep should allow IRC/RAP to revise the financial reporting schedule to accommodate PVOs that cannot obtain financial data from inside Afghanistan in the time presently allowed.

A.I.D./REP PERFORMANCE

Findings

A.I.D./Rep management of RAP has focussed on the RAO/Peshawar review and approval of grants and the resolution of A.I.D. bureaucratic and policy issues. With respect to the review process, the major effort concerned the setting of selection criteria and the application of these criteria to maximize project impact. The close involvement of the RAP project manager in the review process has clearly improved the overall quality of activities funded by RAP. A number of poorly conceived proposals were turned down or substantially improved as a direct result of A.I.D./Rep participation in the reviews.

Locating review and approval responsibilities for most RAP grants in RAO/P was a good decision. Located in Peshawar, the RAO has frequent contacts not only with RAP grantees, but also with many other organizations operating inside Afghanistan. This speeds up and improves the approval process for simple relief and rehabilitation activities.

The main problem with the A.I.D./Rep review process is that it is unstructured. Frequently, issues were raised that were unrelated to the selection criteria and therefore complete surprises to IRC and the PVOs. This made it difficult for the PVOs and IRC to prepare proposals that satisfactorily addressed what A.I.D./Rep considered to be key feasibility or policy issues. Also, the system does not provide for coordinated inputs from all of the concerned A.I.D. offices in Peshawar and Islamabad. Some of the activities that were approved quickly may not have received adequate review within A.I.D./Rep. In one case when the Agricultural Development Officer (ADO) did get a chance to comment (a MCI raisin production project), important substantive issues were raised but not systematically addressed in the review process.

A related problem is that, when issues arose, lines of communication frequently became confused. Some PVOs dealt directly with RAO/Peshawar and A.I.D./Rep/Islamabad rather than through IRC/RAP, usually because they felt that IRC/RAP was not effective in communicating their concerns to A.I.D./Rep or explaining A.I.D./Rep's concerns to them. At times, Peshawar and Islamabad communicated conflicting messages to IRC and the PVOs. It should be noted that most of the 27 subgrants were simple and noncontroversial. These were approved relatively quickly, although rarely within the time frame provided for in the project design. Nonetheless, the project approval system should assure that: (1) IRC/RAP and the RAP project manager be kept as fully informed as possible of communications between A.I.D./Rep and RAP grantees regarding RAP-funded activities, and (2) Proposals are distributed to and reviewed by concerned offices (mainly, the ADO and the program office) immediately upon receipt from IRC so that all A.I.D. comments can be obtained and quickly communicated to IRC and the PVO.

The particular case of MCI should be noted here. MCI, which is based in Quetta, has received only two grants under RAP, both in 1988. The first was an emergency grant that took four months to approve, and the second was a survival grant that was approved in about two months. MCI has three expatriate agriculturalists and a highly qualified Afghan engineer on its staff, and has explored several possibilities for RAP funding of agricultural projects. One proposal for a raisin production project was encouraged in Islamabad, approved by IRC, and turned down by RAO/Peshawar. Another proposal, encouraged by Islamabad staff as a poppy substitution project, was rejected because it was located in a poppy growing area.

MCI is still interested in RAP funding but is reluctant to prepare proposals for RAP funding because it is not sure what the guidelines are. One problem is that the

criteria are too general. The other problem, however, is that, being located in Quetta, MCI finds it easier to communicate with Islamabad than with A.I.D. and IRC in Peshawar. Setting up a system as described above should help MCI communicate with A.I.D. more effectively and understand RAP better. This, however, will have to be supplemented by more frequent communications and visits between MCI and IRC.

The solution to the unstructured and at times confusing approval process is to improve communications between IRC/RAP, the RAO project manager in Peshawar, and the program and agriculture offices in A.I.D./Rep/Islamabad. This can be accomplished by regular meetings to discuss progress, implementation problems, and design and policy issues related to ongoing or proposed grants. The A.I.D./Rep approval process is part of a larger issue concerning the overall RAP management structure which is discussed in the section on project design.

A.I.D./Rep involvement in the implementation of RAP grants has been largely limited to receiving quarterly reports from the PVOs and IRC, and resolving policy and bureaucratic issues. This latter task has been time consuming and has in general been handled efficiently and expeditiously. RAO/Peshawar and the A.I.D./Rep grants officer have been diligent in trying to resolve such issues as overhead rates, procurement of restricted commodities, PVO eligibility, and cost standards used in reviewing budget proposals. The efficient implementation of project activities seems to have been the main consideration in the resolution of most of these issues. One important exception is the requirement that PVO administrative costs not directly related to RAP grants but funded by RAP be fully documented. This is extremely time consuming and does not seem to provide measurable benefits to A.I.D..

Another implementation issue, the procurement of seeds, fertilizers and pesticides, needs urgent review. As discussed below in the section dealing with the technical capabilities of PVOs, these inputs are critically needed to return small farmer agricultural productivity to pre-war levels. Any blanket waivers that can facilitate the provision of these commodities through RAP should be pursued as soon as possible.

A.I.D./Rep has not devoted sufficient attention to improving the quality of PVO monitoring and reporting. As noted above, most quarterly reports have not been useful for management purposes. The commendable effort put into the review and approval of RAP grants should have been followed-up with an equally serious effort at improving the flow of information on project implementation to A.I.D./Rep. This would have required an early intervention by the project manager to improve PVO and IRC quarterly reports and have IRC/RAP strengthen its independent monitoring capacity as provided for in the cooperative agreement. Until this is done, A.I.D./Rep will remain inadequately informed about the performance of this project.

Recommendations:

- For activities that are likely to raise policy issues within A.I.D./Rep, the approval process should provide for a brief justification and summary description for distribution to concerned offices prior to the preparation of the full proposal. Comments from these offices would be communicated to IRC and the PVO as guidance in preparing the proposal.
- A.I.D./Rep should establish a system to ensure that the program office and ADO are at least given the opportunity to participate in the review of proposals that appear to raise important policy or technical issues. Comments should be assembled by the project manager and communicated to IRC.

- A.I.D./Rep should require more substantive quarterly reports and should take a more active role in assessing the implementation of RAP grants and initiating corrective actions as appropriate.
- In addition to attending the chief of party meetings, IRC/RAP and the RAO project manager should meet regularly with the agriculture, program and other concerned offices in Islamabad to discuss implementation, design, and policy issues relating to ongoing and proposed subgrants.
- A.I.D./Rep should make every effort to facilitate the provision of seeds, fertilizers and pesticides to through RAP.

SECTION TWO

PROJECT DESIGN ISSUES

INTRODUCTION

The previous section discussed implementation issues related to the project as presently designed, and assessed the performance of the PVOs, IRC/RAP and A.I.D./Rep in the implementation of project activities. The recommendations dealt with steps that A.I.D./Rep and IRC/RAP should take to improve the implementation of individual RAP-funded activities. In logical framework terminology, section one dealt with the achievement of project outputs.

This section analyzes key design issues that have implications for the achievement of the project purpose: in other words, increasing agricultural productivity and rural incomes, and providing basic necessities for Afghans who remained in, or wish to return to, Afghanistan. These issues are:

1. What should be the role of PVOs in providing basic necessities and increasing agricultural productivity in Afghanistan under present circumstances?
2. How much effort should A.I.D./Rep make in assuring adequate coordination of RAP grantees with other PVOs, with A.I.D. contractors, and with the Afghanistan Interim Government (AIG) and the Government of Pakistan (GOP), and what are the appropriate mechanisms for achieving this coordination?
3. What level and type of monitoring effort is appropriate given A.I.D./Rep's management needs, conditions inside Afghanistan, and the fact that this is a PVO financing project rather than a project implemented directly by an A.I.D. contractor?
4. What verifiable indicators of project success should A.I.D. monitor and evaluate in the management of this project?
5. What is the most appropriate RAP management structure taking into account the type of activities funded by RAP as well as A.I.D./Rep staffing constraints?

PROJECT OBJECTIVES AND IMPACT INDICATORS

This section addresses the following point in the scope of work:

Review the current mix of PVO activities to determine whether A.I.D. has set priorities and allocated funds in a measure proportionate to the needs inside Afghanistan and to the PVOs' ability to respond to those needs.

This raises the issue of how A.I.D. should measure success in achieving project objectives.

The project goal is:

To assist war-affected Afghans who wish to remain in or return to their home villages and towns.

The project purpose is:

To increase agricultural productivity and rural incomes and provide basic necessities in stabilized Afghan communities.

There is no "logical framework" for this project, but the following would be appropriate indicators of purpose achievement:

- Number of farm families benefitting from increased productivity;
- Increases in irrigated area;
- Increases in agricultural production;
- Increases in rural incomes; and
- Increases in the availability of basic necessities.

The project outputs are related to the four categories of subgrants and include the following:

- Rehabilitated irrigation systems;
- Rehabilitated roads;
- Quantities of agricultural inputs and equipment;
- Nonagricultural income generating activities;
- Quantities of basic necessities distributed to beneficiaries or made available through cash-for-food activities; and
- Number of repatriated families receiving assistance.

A basic problem in evaluating this project is that there are no end-of-project targets and no progress indicators either at the output or purpose levels. This was appropriate at the time that the project was designed. Emergency, relief, and rehabilitation needs could not be predicted, and the project was designed as a flexible instrument to address needs as they were identified. The issue for this evaluation as well as for A.I.D./Rep in the future is: What objective indicators should A.I.D./Rep management use in measuring the degree of success of this project?

The present A.I.D./Rep approach for setting indicators of project success is to accept that, under present circumstances, in Afghanistan, end-of-project targets related to agricultural productivity and rural incomes cannot be easily quantified and probably cannot be monitored. Consequently, the project has been managed as a source of funds for PVO activities that fit within one of the four categories of RAP grants. The only indicator of project success is the achievement of the output targets specified in each approved grant. Poor project performance consists of a high failure rate in achieving grant output targets. Good performance is a low failure rate. No systematic attempt is made to measure, at the overall project level, progress in achieving the stated project purpose.

Under this approach, managing for maximum impact requires that A.I.D. focus on the careful review of each grant to assure feasibility and careful monitoring of each subgrant to minimize implementation problems. The primary basis for allocating funds is the likelihood of achieving grant objectives, and the overall project objective becomes the rehabilitation of rural infrastructure and the delivery of agricultural inputs and

equipment into Afghanistan. The unstated rationale for this objective would be that Afghanistan's needs for this type of assistance greatly exceed RAP resources and simply providing it is enough to justify the project. There is the further implication that rehabilitation and agricultural inputs will inevitably increase agricultural productivity and rural incomes, thereby automatically contributing to the project purpose.

An alternative approach for setting indicators of project success is to set purpose and output targets based on some assessment of needs inside Afghanistan and an assessment of PVO capacities to meet those needs. This is the approach reportedly being used by the U.N. agencies. Through surveys inside Afghanistan, they have identified needs and requested proposals from implementing organizations (PVOs) to address those needs. Priorities have been set by sector and by region for evaluating these proposals.

There are a number of important project decisions that would be facilitated and probably improved if there were more specificity in the project purpose targets and a stronger link between the project purpose and the project outputs. These include:

1. What should be the relative RAP funding priorities for survival grants, rehabilitation, and agricultural development?
2. Within the "village assistance" category of subgrants, what should be the relative priorities of irrigation, rural roads, agricultural inputs, and modern agricultural equipment? Should RAP encourage projects that combine these activities to meet an area's overall needs?
3. What is the relative importance of small farmer production versus the generation of sustained agricultural employment or the generation of short-term employment in self-help projects with poorly defined longer-term benefits?
4. Should income generating projects for women be given priority for funding?
5. What is the impact on the project purpose of limiting the number of PVOs? What would be the impact of reducing the role of non-U.S. PVOs?
6. What is the impact on the achievement of the project purpose of allocating \$1 million to the CARE food-for-work project?

These issues, which are basic to the management of this project at the purpose level, are difficult to address objectively without a systematic consideration of the situation and needs inside Afghanistan as they relate to this project. The evaluation team feels that a useful needs assessment can be based largely on information already existing in Peshawar and Quetta.

In the final analysis, it should be emphasized that RAP is designed as a project to finance well-designed and implementable PVO projects that contribute to the project purpose. The main focus of RAP management, therefore, will always be on whether sound PVO activities were selected and whether their output targets were achieved. The issue raised here is whether additional measures of project success would improve the management and eventual purpose-level impact of the project.

Increased attention to project purpose could be relatively simple. Initially, selection criteria related to purpose-level priorities would have to be established. (See Annex B for suggested criteria.) Then, at the beginning of each fiscal year, A.I.D./Rep and IRC RAP would prepare a work plan that identifies priority needs to be addressed with RAP grants. These would be based on discussions with RAP grantees and other organizations implementing relief, rehabilitation, and agricultural development programs in Afghanistan. These priorities would be communicated to interested PVOs who would

then have some indication of the types of projects RAP is particularly interested in funding. At the end of the year an annual report would be prepared dealing not only with the implementation of individual RAP grants but also discussing with as much quantification as possible the overall impact on agricultural productivity and rural incomes.

Recommendations:

- A.I.D./Rep should consider preparing annual work plans, jointly with IRC/RAP, based on identified constraints to increasing agricultural productivity and rural incomes in Afghanistan and using those plans as a basis for measuring progress in achieving the project purpose.
- A.I.D./Rep should prioritize project outputs to reflect purpose-level targets and communicate these priorities to IRC and the PVOs so that they are reflected in the subgrant approval process.

THE ROLE OF PVOs IN THE RURAL ASSISTANCE PROJECT

A.I.D. is the only bilateral donor with a substantial program of humanitarian assistance and developmental support underway inside Afghanistan. The PVO Co-Financing and RAP Projects are only a small, if important, component of the A.I.D./Rep's overall cross-border assistance program, which includes major sectoral support projects (health, education, logistics, agriculture and rural rehabilitation, planning, and private sector agribusiness) implemented by private contracting firms, as well as indirect support to a number of ministries of the Afghan Interim Government.

PVOs, and the assistance activities that they undertake, represent an important counterpart to the activities of the sectoral support project contractors. In Afghanistan, under conditions where project implementation strategies are still being tested, the diverse PVO activities represent important alternatives to those activities supported by the A.I.D./Rep contractors. Simply put, PVOs go places where A.I.D./Rep contractors do not go; and PVOs provide some kinds of assistance that the A.I.D./Rep contractors do not provide.

As the A.I.D./Rep co-financing of PVOs under RAP has evolved from supporting exclusively cash-for-food assistance to more rehabilitation and developmental activities, the implications of the PVO role in the A.I.D./Rep program take on greater significance. This section reviews the evaluation team's findings on the strengths and weaknesses of PVOs as implementing partners for A.I.D. in Afghanistan, from the organizational and technical standpoint, and makes recommendations for their continued participation and closer coordination with ongoing sectoral support projects.

Background

In the spring of 1985, the U.S. government began a program of providing cross-border humanitarian assistance from Pakistan to war-affected populations in Afghanistan. Initially, the major components of this program were health, education and cash-for-food activities whereby cash grants were distributed directly to beneficiaries inside the country. The aim of this program was to provide immediate relief to war-affected civilian populations that would enable them to remain in their villages and towns, and not be forced to join the ranks of the internally displaced or the refugees settled in Pakistan.

Under the combat conditions that prevailed throughout Afghanistan at the time, the only means of implementing this humanitarian assistance program was by channelling funds through a number of PVOs that had already begun providing limited assistance inside the country. These predominantly European PVOs had, since the early 1980s, developed contacts and working relations with Afghan mujahideen groups in Peshawar and Quetta in Pakistan, and with mujahideen commanders in a number of regions within Afghanistan itself. Subsequently, A.I.D./Rep began to develop a stronger and more unified assistance delivery capacity through its funding of a number of cross-border sectoral support projects implemented by private contractors. However, in the absence of a cohesive and centralized political structure capable of guaranteeing secure access to all parts of Afghanistan, PVOs initially represented the only means available to the A.I.D./Rep for implementing its program of cross-border humanitarian assistance.

Since the signing of the Geneva Accords and the subsequent withdrawal of Soviet troops from Afghanistan, the scope of A.I.D.'s humanitarian assistance to Afghanistan has changed from one of exclusively relief assistance to one of rehabilitation assistance. In anticipation of peace developing in Afghanistan, A.I.D./Rep strengthened its level of support to an increasing number of PVOs that were becoming involved with cross-border rehabilitation projects. The office of the A.I.D./Rep was not alone in its programming optimism. A number of United Nations organizations, under the coordination of the Office of the Coordinator for Humanitarian and Economic Assistance Programmes Relating to Afghanistan (UNOCA), began to fund a portfolio of PVOs similar to A.I.D.'s for similar types of assistance activities in Afghanistan.

Sadly, conflict persists throughout much of Afghanistan, not only between the Kabul regime and mujahideen forces but between factions of the mujahideen as well. This continuing conflict has dashed the hopes of the Afghan people and stymied the good intentions of the PVOs, and the bilateral and the multilateral donors alike. In hindsight, assistance programs with longer term development objectives that appeared appropriate in early 1989, now appear ambitious or premature. Nevertheless, the need for relief and rehabilitation assistance remains and opportunities for effective PVO projects exist in a number of areas in Afghanistan.

Strengths and Weaknesses of PVOs

Findings

The PVOs supported by A.I.D./Rep in its cross-border humanitarian assistance program have demonstrated an enduring capacity to deliver specific types of assistance to specific areas of Afghanistan. The reasons for this lie in the depth and continuity of their grass-roots contacts inside Afghanistan. These contacts, built up in some cases over the course of numerous assistance missions, enable PVO staff to deal directly with local authorities and their constituent populations in assessing needs and determining the appropriate means of providing relief and rehabilitation assistance. Afghanaid, for example, has been working with Commander Ahmed Shah Massoud and the Shura-i-Nazar for more than five years, providing emergency and survival assistance to populations in the Panjshir Valley and districts of Badakhshan Province. Similarly, AFRANE and Solidarite have been providing survival assistance under veritable combat conditions to populations surrounding Kandahar and Herat cities from the early 1980s. RAP funding of the Afghan PVO, CHA, represents support for one of the only humanitarian groups attempting to assist the population of the war-torn central districts of Farah Province.

The high level of commitment of PVO staff and the loyalty this commitment generates among their local staff creates enduring links between the PVOs and local

authorities inside of Afghanistan with whom they work. These links facilitate the implementation of local self-help activities such as *karez* cleaning and the repair of rural roads. The relatively low salaries accepted by PVO expatriate staff -- as little as one-half of A.I.D. staff and A.I.D. contractor salaries -- combined with low overhead costs -- as little as one-third of an A.I.D. contractor's overhead -- make PVOs very cost-effective for implementing simple relief and rehabilitation activities. In addition, unlike the A.I.D. contractors, PVOs, with their typically small staff, simple administration, and minimal procedural constraints are able to adapt more quickly to evolving political circumstances and assistance priorities in Afghanistan.

Nevertheless, there are many drawbacks to utilizing PVOs for the implementation of assistance projects. Because of their low level of staff support and compensation, PVOs often have difficulty attracting technically qualified and experienced field staff to manage effective relief and rehabilitation programs, not to mention projects more developmental in scope. This inexperience often results in poor project planning as well as poor levels of accountability for project activities and funds disbursed. A number of these limitations are discussed in detail in the discussion of PVO technical capacity below. In addition, many PVOs are guided by operational principles that are frequently incompatible with, or inimical to, the developmental goals embraced by potential donors. Adherence to these principles may inhibit some PVOs from coordinating their efforts with the larger assistance community. Without such coordination, cooperating agencies are unable to develop consistent policies governing the provision of humanitarian and developmental assistance. Without consistent policies, A.I.D. contractors and some PVOs may find themselves at odds with other PVOs on such basic concerns as the level of commodity pricing subsidies and the types of commodities to subsidize.

Regardless of these drawbacks, however, in the absence of effective government counterparts and an institutional structure through which to implement programs of relief and rehabilitation assistance in Afghanistan, PVOs represent an important complement to the A.I.D./Rep sectoral support projects. Effectively managed, PVOs can be used to fill the gaps in both the geographical and sectoral coverage of the contractors implementing sector support projects.

As more American PVOs become capable of implementing cross-border projects, it is logical that they should receive the support and backing of the U.S. government. As a consequence, European PVOs should be encouraged to draw greater support from their own governments and the multilateral agencies that are beginning to fund cross-border assistance activities. Clearly, as the United Nations agencies and bilateral donors become more supportive of cross-border relief and rehabilitation projects, neither American or European PVOs will want for project funding. In fact, many PVOs may soon reach their capacity for absorbing new funding and developing new projects.

Nevertheless, in its consideration of future funding for European PVOs, A.I.D./Rep should not discount the flexibility of operation that the support of European PVOs can offer the cross-border humanitarian assistance program. A review of RAP grant activities indicates that European PVOs have been engaged in simpler relief and rehabilitation activities that are more consistent with RAP objectives than the American PVOs (see Annex B). European PVOs retain the enduring grass-roots contacts with important regional and local authorities in Afghanistan and their assistance activities can, and do, have an impact on the activities of American PVOs and A.I.D./Rep sector support projects. In fact, A.I.D. funding under RAP, and the evolving level of oversight that funding implies, may represent the only leverage that A.I.D./Rep can apply to make both American and European PVO relief and rehabilitation activities consistent with A.I.D./Rep policy as implemented by its major sectoral support contractors.

Recommendations:

- PVOs represent a cost-effective means of providing relief and rehabilitation assistance inside Afghanistan. They are able to meet certain needs, through a diversity of methods, that are beyond the capacity or the mandate of A.I.D./Rep contractors and technical counterparts to meet. A.I.D./Rep should continue to support PVOs as part of its program of cross-border humanitarian assistance to Afghanistan.
- European PVOs have demonstrated an enduring commitment to, and capacity for, implementing simple relief and rehabilitation activities. A.I.D./Rep should continue to fund and support the activities of European PVOs in Afghanistan.

Technical Capacity of PVOs in the RAP Program

Findings

Just as PVOs vary in administrative capacity, their capabilities in managing agricultural and construction activities are diverse. Mercy Corps International (MCI) employs three Canadian agronomists to manage their agricultural portfolio; they serve as project field officers as much as technical advisors. By contrast, Afghanaid, which manages a multi-million dollar agricultural program, has one expatriate agriculturalist who is not a graduate as yet. These same differences are found in the Afghan staff that the various PVOs employ.

Up until the early 1970s, Kabul University had a creditable agricultural college, staffed by an A.I.D.-funded Wyoming technical assistance team. Some of the PVOs, such as Afghanaid and SCF/US, employ Kabul University agricultural graduates to oversee their programs. Because of restriction on travel of U.S. citizens to Afghanistan, the employment of Afghan nationals with good field experience is a wise choice for PVOs to have made. Foreign agriculturalists, even those who can enter Afghanistan, typically lack sufficient knowledge of the country and tend to have short tenures that limit their effectiveness. Perhaps the greatest limitation to PVO effectiveness, however, is that most are staffed by volunteers who are inexperienced in their own fields and are, therefore, not able to make decisions based on years of practical field work. Because of the lack of an agricultural policy base, the weakness of the AIG/Ministry of Agriculture in setting regulations and standards, and the impatience that some PVOs have with the current low level of activities, there is a need for close review of agricultural projects proposed by PVOs. Otherwise, A.I.D./Rep will be unable to prevent PVOs getting involved in agricultural development activities that their staffs are unqualified to implement.

Planned Activities

During the course of their meetings with the evaluation team, the staff of many PVOs indicated that they would like to become involved in longer-term agricultural activities. Partly because they have strengthened their capacity with an increased number of qualified expatriate and Afghan agricultural staff, and partly because they wish to remain in the areas where they have good working relationships with the local administration, PVOs are being pressed by donors to develop longer-term commitments. While such commitments may make good sense from a programing viewpoint, the unstable political and military situation persists in Afghanistan, and high levels of staff turnover and lack of technical expertise of current staff persist among many PVOs. At the very least, IRC RAP needs to take account of these conditions and to assess

carefully any proposals that extend the duration and objectives of the current grant system.

Among the types of activities for which PVOs are seeking funds are the following:

- **Agro-Forestry:** some PVOs would like to expand into reforestation for erosion control and fuelwood production.
- **Animal Health:** MCI is operating a sheep and goat vaccination program and would like to expand to training of para-veterinary personnel.
- **Seed Multiplication:** Afghanistan has contracted with farmers for seed multiplication in Badakhshan. They would like to expand this program into field trials and selection of improved seed.
- **Distribution of new seed varieties for cash and food crops:** Afghanistan sees a need to distribute seed potatoes and new varieties of vegetables in northern Afghanistan. MCI would like to explore the possibility of introducing cumin in the southwest as a cash crop.
- **Infrastructure:** PVOs have suggested construction of grain storage structures in the north and raisin-drying buildings in the south (MCI's "kishmish-khana").
- **Roads:** To date, most PVOs have been supporting the repair of tracks and roads through cash-for-work programs. They would like to assist in the repair of major market roads linking the eastern and southern regions of Afghanistan to Pakistan.

Policy Issues

Many of the proposed expanded activities not only broach technical issues but cross into policy areas, and have implications for other A.I.D./Rep programs that are either underway or in the planning stage. For example:

- **Seed sale and give-away programs:** Taken as an aggregate, PVOs may have enough impact to influence market prices in some areas. When seed is provided free of charge on a continuing basis, programs and merchants attempting to reestablish markets, especially for improved seed, will be discouraged. This is already a problem in the north where improved seed is marketed at 850 Afs/seer and wheat for milling is sold at 750 Afs/seer (a difference of only about 3 U.S. cents/kg.).
- **Introduction of new cash and food crops:** These involve marketing expertise and a macroeconomic overview to which PVOs may not be privy. While the introduction of new vegetables may be elementary, donors have to remember that no extension system exists in the country at present, and the introduction of new varieties with resultant pest, acceptance, and marketing problems should be looked at on a case-by-case basis by the A.I.D./Rep agricultural office.
- **Involvement with former state farms:** Two of the RAP projects are located on state farms. The management of these farms, as far as the evaluation team can tell, is now in the hands of the mujahideen and the division of the harvests may be problematic. SCF and Mercy Fund hope to establish a board of directors to run the farms as a parastatal organization. In the meantime, there are technical decisions to be made, and ownership claims to be settled. Investment in multi-year crops and major rehabilitation schemes

should be avoided in these areas; one-season seed multiplication projects may be more appropriate.

- **Pesticides:** A.I.D. regulation 16 restricts the use of pesticides on other than experimental or training bases, or, in the case of locust infestations for which pesticides are pre-approved and an emergency situation is declared, until an environmental analysis is done. Both Sunn Pest and locust are reported to have become a problem in some regions of Afghanistan as a likely result of the lack of pesticide application during the war years and a breakdown of biological control systems. Early plantings and locust seed pod gathering (two normally effective methods of pest control) have not been possible in some areas, and the number of natural predators, such as chickens, have decreased during the war. Field staff are reporting wheat losses as high as 30 to 50 percent in the north. SCF reports large losses of fruit trees that are in weakened condition as a result of lack of water and no pest control over the last ten years. The arguments for pesticide purchase are indeed persuasive, and it may be that, if A.I.D./Rep were able to get a waiver for pesticide use, PVOs could have field staff trained in pesticide application. This is another issue for A.I.D./Rep to consider and resolve. Whatever the decision, all PVOs need to follow the same policy and this should be monitored by IRC. At least one PVO has purchased pesticides in violation of regulation 16, and has dispensed treated seed.
- **Livestock and veterinary activities:** None of the PVOs has qualified veterinary staff, nor do they need to hire them if they restrict their work to simple vaccinations, and rigorously research what vaccines are appropriate, needed, and do not require cold chains. Their field staff can easily be taught simple vaccination techniques and even external parasite treatments, and these types of proposals should be considered for funding. The development of paratechnical veterinary staff does not fall within the purview of RAP, and other donors are active in the field at this time. Mercy Fund may propose a poultry project in the near future. The danger of A.I.D. funding such projects in food deficit areas is that the fowl may be in direct competition with food aid recipients for grain. Any such proposal should be considered by the A.I.D./Rep Agricultural office in terms of the total assistance program.
- **Fertilizer:** New grants will have to deal with recently stated requirements for fertilizer waivers. Most PVOs now distribute technical packages to farmers: fertilizer is given or sold along with seeds and handtools. If this program is to be continued intact, PVOs will have to obtain individual waivers or IRC will have to obtain a waiver to cover all non-U.S.-purchased fertilizer. Another alternative is for IRC to obtain fertilizer through current A.I.D. projects such as the Agricultural Sector Support Program.
- **Procurement of agricultural inputs:** For the most part, PVOs are now purchasing agricultural inputs in Pakistan for exportation into Afghanistan. The evaluation team estimates that the total procurement of items such as seeds, fertilizers, and handtools is somewhere in the neighborhood of \$1 million for 1989. This level could increase as the number of activities increases and non-RAP sources of inputs decline.

Agricultural inputs such as fertilizers have foreign exchange costs and are subsidized by the GOP. The ADO has been told by the GOP that a list of restricted commodities has been issued that severely limits the commodities that can be exported to Afghanistan. This could adversely affect RAP implementation. One solution to this problem would be for the ADO to assess the foreign exchange and budgetary impact of input procurement by RAP grantees. If the impact is significant, IRC/RAP should

review the procurement lists in each proposal and coordinate that procurement with A.I.D. Rep. If the impact is insignificant, this should be communicated to the GOP in an effort to improve relations with the PVOs.

In sum, PVOs have demonstrated a capacity to implement rural rehabilitation projects. For a number of PVOs, the addition of Afghan technical field staff has provided RAP-funded activities with a continuity that was lacking at the program's inception. Considerable agricultural and engineering expertise is available in both Peshawar and Quetta among PVO expatriate and Afghan staff, as well as among the A.I.D. sector support project contractors. Thus, PVOs have the ability to draw on local expertise to address technical issues that arise in their project planning and implementation. Yet, until they are capable of developing and fielding their own technical experts, PVOs will be limited in the scope of developmental activities which they can undertake. Nevertheless, IRC/RAP should be authorized to consider funding longer-term agricultural activities on a case-by-case basis.

Recommendations:

- Because of their limited technical capacities, relative lack of development expertise, and limited ability to support qualified staff for extended periods of time, most PVOs are not well suited to implement longer-term development projects. Under RAP, PVOs should be funded primarily to implement short-term relief and rehabilitation activities.
- In analyzing the technical capabilities of PVOs, the evaluation team identified a number of technical issues that do not affect project design but are important to the success of the project. These are:
 - Investment in multi-year crops and major rehabilitation schemes for state farms should be avoided. One-season seed multiplication projects may be more appropriate.
 - Considering the overriding needs for pest control in Afghanistan, a waiver to A.I.D. regulation 16 restricting pesticide use on A.I.D.-funded projects for PVO agricultural activities should be requested by A.I.D./Rep. If granted, A.I.D./Rep and IRC/RAP must impose regulations for pesticide use by RAP subgrantees and IRC/RAP must develop a system to monitor adherence to these regulations.
 - A.I.D./Rep and IRC/RAP should discourage proposals for poultry projects in food-deficit areas of Afghanistan.
 - IRC/RAP should obtain waivers for all RAP grantees to cover all non-U.S. purchased fertilizer. Alternatively, IRC/RAP should be authorized to obtain fertilizer through current A.I.D./Rep sectoral support projects.

COORDINATION

Findings

The coordination of policy and implementation is an issue that concerns all PVOs and bilateral and multilateral agencies engaged in providing or supporting cross-border humanitarian assistance to Afghanistan. The following section reviews the evaluation team's findings on the level and nature of coordination among those agencies directly concerned with RAP activities.

Coordination Among PVOs

All PVOs funded under RAP are members of one or both of the regional coordinating committees ACBAR and SWABAC. Each PVO participates in the sectoral subcommittees (for example, the agricultural subcommittee and the construction subcommittee) and related task forces (such as horticulture, seeds, and fertilizer) sponsored by the coordinating bodies in which basic policy guidelines governing PVO assistance activities are developed. Each PVO also participates in the regional subcommittee meetings of these coordinating bodies where concerned PVOs attempt to coordinate their assistance activities to avoid duplication, or to harmonize policy decisions that could otherwise jeopardize the success of one or another PVO activity in the same or adjacent areas of Afghanistan.

However, it is more often the case that the need to coordinate activities arises in the field rather than in the conference rooms of Peshawar and Quetta. In a number of cases, the evaluation team was told that RAP grantees had turned over planned activities to another PVO because of its field staff's superior contacts or because they could better implement these activities. Such coordination has inspired a number of PVOs to consolidate their activities in areas where they have accumulated considerable implementation experience. Afghanaid, for example, has turned over a number of its activities in Kabul and Kandahar to SCF/US in order to concentrate its resources in northeastern Afghanistan where it has been supporting projects for nearly five years. Similarly, Solidarité Afghanistan was able to dissuade MCI from undertaking projects in districts around Kandahar city that would duplicate its own. Unfortunately, having established its territorial preeminence, Solidarité has yet to fund or implement its proposed projects in that area.

There is little evidence to suggest that the A.I.D. project managers or IRC/RAP facilitate the coordination of field activities among their grantees. The guidelines developed for RAP proposal submission are general and require only a statement from applicants that they are willing to abide by the standards and recommendations established by the relevant ACBAR and SWABAC sectoral subcommittees. The grant review process, both at the IRC/RAP coordinator's level and at the A.I.D./Rep project manager's level, is carried out on a case-by-case basis and, to date, no apparent attempt has been made at either level to enforce coordination or impose specific technical and policy standards to be applied to project implementation. Nevertheless, IRC/RAP, in its funding capacity, has the opportunity to take a more active role in guaranteeing that certain standards and guidelines are observed by its grantees.

Coordination Between PVOs and A.I.D./Rep Contractors

The evaluation team also found little evidence of substantive coordination between RAP grantees and the relevant A.I.D./Rep sectoral support project contractors. Aside from Management Sciences for Health (MSH), the medical sector support contractor whose relations with the health PVOs is discussed in Part Two of this report, contacts between RAP grantees and other A.I.D./Rep contractors are informal and unstructured. The most frequent contacts mentioned were between grantees and the agricultural staff of VITA. These contacts were limited to technical consultations and seldom broached the issue of coordination of field activities.

Just as IRC/RAP, in its funding capacity, has the opportunity to promote the observance of implementation standards and guidelines, so it can encourage the development of a grantee implementation policy that is consistent with that of the relevant sectoral support contractors and of A.I.D. Rep in general. With the development of proper channels to the project officers in Islamabad, IRC/RAP can assist A.I.D./Rep in assessing the compatibility of proposals submitted by potential grantees with the food

supply, area rehabilitation, and private sector activities carried out by the sectoral support project contractors. In this way, IRC/RAP can discourage potential grantees from pursuing policies and field activities that could jeopardize the sector support projects such as the conflicting pricing policies for commodity inputs cited above in the discussion of PVO technical capacity. At the same time, such coordination can lead to more cooperative and effective project implementation between the PVOs and the A.I.D. contractors, as with the joint procurement of agricultural inputs and vehicles.

There is no single assistance implementation strategy that will meet all the requirements of all the beneficiaries throughout all of Afghanistan. Some segments of the country's population may be able to pay for agricultural inputs and basic commodities while others may not. Through its support for PVOs, and the coordination among PVOs and its own contractors, A.I.D./Rep can maintain a diversity of approaches that address the needs of the Afghan people.

Coordination Among the PVOs, the AIG, and the GOP

Nearly all of the PVOs supported by RAP reported that they made an effort to keep both the concerned representatives of the GOP (especially the provincial Commissionerates for Afghan Refugees) and the AIG (especially the Ministry of Reconstruction) notified of their activities in Afghanistan. The evaluation team met with representatives of the GOP and the AIG. According to the GOP spokesmen, clear procedures have been established to which PVOs must adhere in order to move commodities up to, and across, the Afghanistan border. If PVOs adhere to these procedures, the spokesmen report, they should expect no undue interference in their assistance activities in Afghanistan. However, the staff of nearly every PVO interviewed by the team expressed concern over the growing difficulty in obtaining working visas for their new staff. Long delays in obtaining visas have proved an obstacle to PVOs in their attempts to strengthen their existing programs as well as to undertake new programs.

Spokesmen for the Ministry of Reconstruction and the Ministry of Foreign Affairs of the AIG complained that the PVOs were not keeping the ministries informed about their activities in Afghanistan. These spokesmen reported that both ministries were willing to provide authorization and assistance to any and all PVOs that want to work inside Afghanistan as long as they coordinate their activities with the ministries. However, the recent announcement by one of the fundamentalist Afghan resistance parties that it will provide its own authorization and assistance to PVOs working cross border is likely to confuse the issue of legitimate authority and complicate PVO efforts to coordinate their activities with Afghan counterparts.

In the evaluation team's estimation, the AIG Ministry of Reconstruction does not currently appear capable of constructively coordinating PVO activities. While there is an obvious need for Afghans to be establishing the relief and rehabilitation priorities for their own country, many PVOs feel that the priorities set by their Afghan contacts within the country are more legitimate than those set by the AIG ministries. Moreover, the staff of many PVOs, including Afghan personnel, feel that active coordination with the AIG would be a political liability and a handicap to their activities inside Afghanistan.

In the short term, PVO project activities in Afghanistan are not likely to suffer any adverse consequences as a result of active cooperation with, or benign neglect of, the AIG. PVO projects in Afghanistan succeed or fail on the basis of local political relations in the project areas, not public relations in Peshawar. The same applies to PVO relations with the GOP. PVOs have relied upon, and continue to rely upon, their informal contacts with the North West Frontier Province (NWFP) government to facilitate access to and from the Afghan border. The team had no clear indication

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that the GOP would restrict the operations of any PVO providing cross-border assistance under the present circumstances.

The long-term implications of PVO relations with the AIG and the GOP are subject to much speculation. For the reasons noted above, the policies of the AIG, as it is currently constituted, will not probably affect PVO cross-border assistance activities either positively or adversely. Conversely, should the GOP find PVO cross-border activities objectionable for political or security reasons, there is no doubt that it would curtail such activities by any means that it sees fit.

Recommendations:

- A.I.D./Rep and its sectoral support contractors should develop closer links with IRC/RAP to ensure that IRC/RAP staff are fully acquainted with policy developments for the implementation of relief and rehabilitation assistance. Only with such links can RAP insure that grantees follow policies that are not counterproductive to those of the A.I.D./Rep and its sector support contractors.
- RAP-funded PVOs should make greater efforts to apprise the AIG of their assistance activities and to take into account the AIG's assistance priorities in planning future projects. However, coordination of activities with the AIG, because of its current limited capacity for coordination, should not be made a condition for RAP funding of PVO applicants.
- PVOs, where possible, should continue to notify the appropriate representatives of the GOP of their ongoing activities that relate to the internal security concerns of the GOP.

MONITORING

Findings

Monitoring cross-border assistance projects in Afghanistan is one of the most problematic and contentious issues facing donor agencies and PVOs alike. The persistence of armed conflict in many areas of the country, the poor condition of roads and the paucity of reliable transport, the relative lack of communications, the extremes of weather and topography not to mention the cultural differences that obfuscate relations between Afghans and non-Afghans, all serve to undermine any agency's monitoring capacity. For the typical PVO, limited field office staff and financial resources and, in some cases, poor management combine to prevent even the most conscientious administrator from adequately assessing the effectiveness of projects supported from Peshawar and Quetta. Removed from the complexities of field operations, donors often fail to understand the political and cultural constraints to effective monitoring and project management in Afghanistan. Nevertheless, however difficult project monitoring may be under the current circumstances in Afghanistan, it is essential to ensure project accountability and project impact. This section reviews the teams findings on the monitoring capacity of the PVOs, IRC/RAP, and A.I.D./Rep.

PVO Monitoring

The evaluation team found that every RAP-funded PVO has developed a capacity to monitor its own projects. The makeup of their monitoring teams (for example, Afghans versus expatriate as principal monitors), the objectives of monitoring missions,

the reporting of results, and the extent to which information gathered is shared with the donor varies considerably from agency to agency. Similarly, the need to establish realistic objectives, to observe and record efforts toward achieving those objectives, and to quantify benefits to recipients, are issues that vary in importance among the PVOs. The differential importance attached to these needs by each RAP grantee is reflected in the quality of their periodic reporting. In all but a few cases, the evaluation team found the RAP grantee reporting, and the IRC/RAP reporting itself, lacks sufficient detail to enable the reader to determine that project objectives had been set and were being met through project activities.

For technical monitoring, a number of PVOs expressed a need to undertake crop-cutting and yield assessments. While this technique would doubtless introduce some scientific measurement to the assessment of project impact, it would require more sophisticated capacity than PVOs now have. Given the far flung locales of the projects, and the fact that such monitoring would require a team of agricultural specialists, the cost of such monitoring might exceed the benefits. A more realistic system, would be the collection of soil samples from project areas and employing agriculturalists now in Peshawar to set seed rates and fertilizer application rates. The subsequent assessment of the recipient's fields, crop, or harvest could be undertaken by skilled monitoring teams.

Irrigation system rehabilitation work needs to be similarly monitored. PVOs need to establish flow rates of *karez* and surface irrigations schemes at the time of their rehabilitation activities in order to measure the impact of their activities over time.

A recent report prepared for ACBAR (Thami, 1989) summarizes very well the difficulties that monitoring teams encounter in Afghanistan, and the dangers of sending teams into the field, even to areas thought to be in the firm control of commanders with whom PVOs have established relations. The comparative disadvantages of relying on either expatriate or Afghan monitors is an extremely complex equation. A number of PVOs have tried to solve the problem by introducing elaborate monitoring procedures with cross-checking and independent verification. American PVOs are at a particular disadvantage because of the restriction on American travel in Afghanistan. MCI has productively employed Canadian agriculturalists who are technically able to technically monitor MCI project activities firsthand.

That such problems are being openly discussed in Peshawar and Quetta indicates the concern with which the topic is viewed. Nearly every PVO has indicated that it would welcome IRC/RAP monitors visiting their projects as long as the visits are coordinated with the target PVO in advance. In this way, PVOs can assure the monitors' security and have staff at the sites to direct them and answer their questions.

One PVO director suggested that IRC/RAP convene a monitoring workshop where realistic standards and guidelines for monitoring could be discussed by staff with field experience. The evaluation team participated in one such meeting where engineering standards were debated and revised to accommodate actual field conditions. All participants agreed that the revised standards could be implemented without undue restrictions and delays. All PVOs had good, practical ideas to share, and the evaluation team was impressed with their cooperative spirit. If a monitoring workshop were to be held in the same atmosphere, much could be gained by all participants.

RAP Monitoring

IRC/RAP has had mixed success with its attempts to develop an independent monitoring capacity. The IRC/RAP coordinator, a French national, has been restricted from leading any monitoring missions because she holds resident status in the United States. A French national hired by IRC/RAP in early 1989 undertook an extensive

assessment mission in southwest Afghanistan. His findings were used by IRC/RAP staff to support the development of the Coordination of Humanitarian Assistance, an Afghan organization dedicated to providing rehabilitation assistance in central Farah Province. The monitor's report on political conditions in Helmand also discouraged IRC/RAP from supporting projects in that province. Unfortunately, the monitor did not have a strong interest in monitoring existing projects and was asked to leave by IRC/RAP.

IRC/RAP has also contracted with independent expatriate monitors for assessment and monitoring reports. One monitor evaluated a proposal submitted to IRC/RAP from an Afghan group seeking assistance for the Nuristan districts of Kunar Province in August 1989. On another occasion, IRC/RAP commissioned a monitor for Coordination of Medical Committees (CMC) to visit AFRANE and Solidarité Afghanistan project sites in Kandahar. While informative about the range of each agency's activities, the monitor's report did not relate these activities to the overall project objectives, nor determine their impact on the target populations.

IRC/RAP's attempts to use Afghan monitors have been even less successful. A pair of monitors was sent to monitor SCF/US and Mercy Fund projects at Ghaziabad in the early summer of 1989. The reports were sketchy and impressionistic, and failed to relate activities observed with the stated objectives of the project. IRC/RAP was also remiss in sharing the reports with the concerned PVOs. Admittedly, the Afghan monitors were not well trained for their assignments. They are currently undergoing a management training course offered for Afghans by IRC. With more conscientious supervision and field experience, RAP's Afghan monitors should be able to handle some of the routine quantitative assignments required of them.

A.I.D. Monitoring

A.I.D./Rep developed a data gathering capacity in 1988 with the employment of an American anthropologist in Islamabad to work with sectoral support project contractors, RAP grantees, and A.I.D./Rep project officers. From these combined efforts emerged important standards for identifying and mapping project sites, and guidelines for project reporting to make quarterly reports more useful for project implementation, management, and planning. These standards and guidelines were shared among all A.I.D./Rep contractors, RAP grantees, and member agencies of ACBAR and SWABAC.

In mid-1989, this monitoring capacity was shifted to the RAO in Peshawar and institutionalized as the Data/Monitoring Team made up of a U.S. national, a Pakistani, and an Afghan. The team's main function is to assess and consolidate the reporting of each A.I.D. sectoral support project contractor. Information from each contractor will be entered into a computerized database in an effort to consolidate the existing information for purposes of project planning and evaluation. The venues for the team's activities are Peshawar and Quetta. The Data/Monitoring Team, as it is currently constituted, has, at this time, no capacity to effectively monitor either A.I.D. contractor or RAP grantee project implementation and impact inside Afghanistan.

Conclusion

The monitoring of RAP activities remains unsatisfactory at all levels. The evaluation team was not able to determine to what extent this project is achieving its objectives, and neither can A.I.D./Rep. One problem is that U.S. residents cannot enter Afghanistan. A more significant constraint is that the implementing organizations, in this case the RAP grantees and IRC/RAP, do not have effective monitoring and evaluation programs. There is an urgent need to develop monitoring methodology that addresses impact (quality) as well as verification (quantity), and field monitors need to be trained in that monitoring. Also, until U.S. residents can enter Afghanistan,

A.I.D./Rep needs to set up an independent monitoring capacity, which for RAP should be IRC/RAP as provided for in the cooperative agreement. The lack of effective monitoring is indicative of a possibly more serious problem, the lack of a felt need on the part of management. If management does not perceive the need for better information, generating it may not have much impact on project performance.

Recommendations:

- To assure the effective management of A.I.D. resources, U.S. residents should be allowed to work in Afghanistan as soon as possible.
- RAP grantees need to increase and improve monitoring and reporting efforts to acquire more specific information on project impact and beneficiaries. A.I.D./Rep and IRC/RAP should introduce minimum but realistic monitoring guidelines for RAP grantees to apply to their project activities.
- IRC/RAP needs to strengthen its own quantitative and technical monitoring capacity, and to develop a regular schedule of independent monitoring of grantee project activities. Independent monitoring should be conducted in coordination with concerned grantees. Additional technical and general monitoring staff will help IRC/RAP carry out these responsibilities more effectively.

MANAGEMENT STRUCTURE

Findings

As noted in the section on project implementation, RAP management responsibilities are divided between IRC and RAO/Peshawar. In addition to monitoring the implementation of grants, IRC oversees the proposal review and approval process - IRC provides guidance to PVOs in the preparation of proposals and is supposed to review them thoroughly before they are submitted to A.I.D./Rep with a recommendation that they be approved. IRC has never had the means to carry out its substantive review responsibilities. Questions from PVOs were often simply passed on to the project manager for answers. A system was set up to send early drafts to the A.I.D./Rep project manager to make sure that all A.I.D./Rep concerns would be addressed in the final proposal. After IRC was sure that A.I.D. would be satisfied, the proposal was put in final form and sent to A.I.D. where it was quickly approved. In time, IRC has become more familiar with A.I.D. concerns and the process has become less time consuming for the A.I.D. project manager. IRC, however, still does not have the expertise necessary for a full substantive review prior to the submission of proposals to A.I.D.

When proposals reach A.I.D., they are reviewed by the project manager in Peshawar and, if they are under \$500,000 (\$50,000 for emergency grants), they are approved by the RAO and the grants officer in Islamabad. Grants over \$500,000 are reviewed in Peshawar and sent to Islamabad with the recommendation that they be approved.

Aside from the coordination problems discussed in the implementation section, the main weakness in this system is that IRC/RAP does not have the technical expertise to participate in the substantive management of RAP subgrants. Most RAP activities have agricultural or construction components, and a growing number have development objectives. Without engineering and agricultural expertise, IRC/RAP is unable to assess the feasibility of these projects. Admittedly, the purpose of the cooperative agreement

is to have IRC assist A.I.D./Rep in the management of the project and perhaps it was never intended that IRC have the capability for the substantive review of grant proposals. In retrospect, however, there seems to be little doubt that if IRC/RAP had been able to perform that function the quality of RAP grants would have improved, and A.I.D./Rep's workload in the review process would have been considerably reduced.

Providing IRC/RAP with the expertise needed to deal with substantive RAP issues would have the following impact on project management:

- IRC would have the capacity to work directly with PVOs to improve their projects. Most PVOs would benefit from this support that is not reliably available from any other source. There is little doubt that this would have a noticeable impact on the quality of RAP proposals received by A.I.D.
- IRC would have the capacity to discuss and negotiate substantive issues with A.I.D. instead of having to accept A.I.D. positions without discussion. This would enable IRC to present the PVO perspective to A.I.D. and more effectively present A.I.D. concerns to PVOs. It would also increase IRC's ability to coordinate with A.I.D. contractors and other agencies carrying out projects in rural areas.
- IRC would be able to monitor technical aspects of RAP grants during implementation. This would help IRC to identify implementation and design problems and either take corrective action or prevent similar problems in future RAP activities. Improved technical monitoring would also improve the content and usefulness of IRC quarterly reports.
- IRC would have the capacity to monitor not only the achievement of output targets but also progress in achieving the project purpose. If the IRC/RAP unit is strengthened, a useful addition to the reporting system would be an annual report discussing achievements at both the output and purpose levels.

A strengthened IRC/RAP could also help expedite and improve the A.I.D./Rep review and approval process. For most proposals, A.I.D./Rep's role would be largely limited to assuring that all steps of the proposal review process were followed. However, for activities that raise policy issues or do not fit neatly within RAP objectives, more in-depth A.I.D./Rep review would be required. Perhaps 10 of the proposals received since the start of RAP would have required this type of review. For this reason it would be useful to set up different review and approval systems for routine and nonroutine RAP activities.

Routine activities would be defined as:

- Survival grants (if they are continued);
- Emergency grants under \$50,000; and
- Simple rehabilitation projects and agricultural activities of under \$500,000 and less than one-year duration.

In short, routine activities would be managed using the existing RAP management system. The main difference would be a greater role for IRC/RAP in the substantive review and management of the project and a clearer definition of activities that do not require substantive review beyond IRC/RAP and RAO/Peshawar. A strengthened IRC/RAP would assure a thorough technical and policy review of these projects prior to submission to A.I.D./Rep. The monitoring of these activities would be the responsibility of IRC/RAP.

Nonroutine activities would be defined as:

- Grants of over \$500,000 and emergency grants over \$50,000. Larger programs are more likely to raise policy questions and issues related to implementation capacity and coordination with other organizations. This calls for a closer independent look by A.I.D.
- Grants that raise policy issues not covered in the selection criteria or that require more than one year to complete, even if they are under \$500,000.
- The first repatriation grants. Once initial policy issues have been resolved, repatriation grants of under \$500,000 could also become routine.

The major management issue is where to place primary responsibility for the review and management of nonroutine agricultural activities. It is the strong feeling of the evaluation team that RAP grantees do not have a comparative advantage in the design and implementation of agricultural activities with longer-term development objectives and should not be encouraged to submit them to RAP for funding. For the few such activities that might be appropriate, we recommend that the ADO have the primary responsibility for review and approval.

A more problematic issue is who should monitor these activities during implementation. Since this can be relatively time consuming, an argument can be made for locating this responsibility in IRC/RAP. A strengthened IRC/RAP would have the capacity to carry out this function using a monitoring and evaluation plan approved by the ADO. If, for A.I.D./Rep staffing reasons, this proves to be advisable, IRC/RAP should participate in the review process, which implies that the grants would be provided under the IRC cooperative agreement. If, however, these activities can be managed directly out of the ADO, they should be funded through direct grants and transferred to the Co-financing Project. Since we would expect very few such grants, there is no compelling need to make this change at this time.

Recommendations:

- IRC should be given responsibility for substantive review, management, and independent in-country monitoring of routine subgrants, and should be provided with the necessary staff to carry out this responsibility. Since these tasks are substantially different from IRC's main program with Afghan refugees, the IRC/RAP staff should be established as an autonomous unit similar to the IRC/UNOCA Mine Awareness Program.
- If IRC/RAP is strengthened, the cooperative agreement should be revised to include technical support for PVOs in the preparation of proposals, technical monitoring of implementation, substantive coordination with A.I.D. contractors, and management for maximum achievement of project purpose.
- All routine grants as described above should continue to be approved by RAO/Peshawar and the A.I.D./Rep grants officer.
- All agricultural activities with longer-term development objectives should be reviewed and approved by the ADO. If implementation is to be managed and monitored by the ADO, they should be funded through direct grants. If IRC/RAP is to have this function, it should be funded accordingly under the cooperative agreement.

SUMMARY OF MAJOR FINDINGS AND RECOMMENDATIONS -- RAP

The RAP evaluation is divided into two parts: implementation issues and design issues. The first part focuses on whether project activities were implemented as planned and whether the output targets of the individual RAP grants were achieved. The second part discusses and makes recommendations concerning those issues that the team considered critical to the achievement of the overall project objective: increasing agricultural productivity and rural incomes and providing basic necessities for those who have remained in Afghanistan or wish to return.

Implementation

The evaluation team was unable to verify to its satisfaction that RAP activities achieved the outputs for which they were funded. An assessment of PVO implementation capacities indicates that, in general, they have an adequate capacity to design and implement simple relief, rehabilitation, and input distribution activities, but not technically complex agricultural and construction projects.

IRC/RAP carried out most of the provisions of the cooperative agreement. A system for the preparation, review, and approval of proposals was set up early and is functioning well. Virtually all reporting requirements are being met on a timely basis. The most important need now is to clarify the selection criteria so that PVOs can have a better indication of the types of activities that qualify for RAP funding. The major shortcoming in IRC's performance is the establishment of an independent monitoring capacity. IRC has not yet prepared a monitoring methodology or an evaluation plan, and IRC monitors have not yet received satisfactory training.

The A.I.D./Rep project manager played a major role in setting up selection criteria for RAP grants and later provided valuable contributions to the review process. The main flaw in the A.I.D./Rep RAP management system is the lack of coordination between concerned offices (RAO, Program, and ADO) in the review process, and the lack of attention paid to the implementation of activities once they have been approved.

Recommendations:

- A.I.D./Rep and IRC/RAP should establish specific selection criteria for each category of subgrant. These criteria should be based on the objectives of RAP and the policy and development concerns of A.I.D. in Afghanistan.
- IRC/RAP should strengthen its independent monitoring capacity and establish a regular program for in-country monitoring of individual grants as provided for in the cooperative agreement.
- In addition to attending the chief of party meetings, IRC/RAP and the RAO project manager should meet regularly with ADO, the program office, and other concerned offices in Islamabad to discuss implementation, design, and policy issues relating to ongoing and proposed grants.

Design Issues

The evaluation team identified five design issues that are important to the achievement of project objectives.

1. What should be the role of PVOs in providing basic necessities and increasing agricultural productivity in Afghanistan under present circumstances?

The team found that the particular strengths of PVOs are their contacts inside Afghanistan, their low operating costs, and their relative effectiveness in identifying and implementing simple relief and rehabilitation activities. Their major weaknesses are their limited management capacity and lack of technical and development expertise. Although the team was not able to carry out a systematic assessment of priority needs in Afghanistan, knowledgeable sources agree that there remains considerable rehabilitation work to be done, and PVOs are recognized as having a comparative advantage in this type of activity.

Recommendations:

- Because PVOs represent a cost-effective means of providing relief and rehabilitation assistance inside Afghanistan and are able to meet certain needs that are beyond the capacity or the mandate of A.I.D./Rep contractors, A.I.D./Rep should continue to support them as part of its program of cross-border humanitarian assistance to Afghanistan.
- Because of their limited technical capacities, relative lack of development expertise, and limited ability to support qualified staff for extended periods of time, PVOs are not well suited to implement longer-term development projects. Under RAP, PVOs should be funded primarily to implement short-term relief and rehabilitation activities.

2. How much effort should A.I.D./Rep make in assuring adequate coordination of RAP grantees with other PVOs, with A.I.D. contractors, and with the AIG and GOP, and what are the appropriate mechanisms for achieving this coordination?

The key issue is coordination among PVOs. The main vehicles for PVO coordination are ACBAR and SWABAC. All RAP grantees regularly attend their meetings. In addition, PVOs coordinate in the field. Coordination, however, does not assure agreement and, as a result, there are overlapping and conflicting programs in some areas. Aside from asking that proposals discuss grantee efforts to identify similar programs and resolve disagreements in the project area, there is not much that A.I.D./Rep can do to resolve this problem.

Coordination between RAP grantees and A.I.D. contractors becomes an issue when sizeable RAP programs are implemented in the same areas as A.I.D. contractor programs. In these cases, coordination is essential to assure consistency of policies and complementarity of activities.

Recommendation:

- A.I.D./Rep and its sectoral support contractors develop closer links with IRC/RAP to ensure that IRC/RAP staff are fully acquainted with policy developments for the implementation of relief and rehabilitation assistance.

3. What level and type of monitoring effort is appropriate given A.I.D./Rep's management needs, present conditions inside Afghanistan, and the fact that this is a PVO financing project rather than a project implemented by a direct A.I.D. contractor?

The monitoring of RAP activities remains unsatisfactory at all levels. The evaluation team was not able to determine to what extent this project is achieving its objectives. A.I.D./Rep is faced with the same problem. One reason is that U.S. residents cannot enter Afghanistan, but the main reason is that the implementing organizations, in this case the RAP grantees and IRC/RAP, do not have effective monitoring and evaluation programs. There is an urgent need to develop monitoring methodology that addresses impact (quality) as well as verification (quantity). Also, until U.S. residents can enter Afghanistan, A.I.D./Rep needs to set up an independent monitoring capacity, which for RAP should be in IRC/RAP as provided for in the cooperative agreement. The lack of effective monitoring is indicative of a possibly more serious problem -- the lack of a felt need on the part of management. If management does not perceive the need for better information, generating it may not have much impact on project performance.

Recommendations:

- RAP grantees increase monitoring and reporting efforts to acquire more specific information on project impact and beneficiaries. A.I.D./Rep and IRC/RAP should introduce minimum but realistic monitoring guidelines for RAP subgrantees to apply to their project activities.
 - IRC/RAP strengthen its own quantitative and technical monitoring capacity, and develop a regular schedule of independent monitoring of individual grants.
4. What verifiable indicators of project success should A.I.D. monitor and evaluate in the management of this project?

Like other PVO financing projects, RAP is difficult to evaluate at the overall purpose level. The project was designed to fund activities identified and implemented by PVOs as part of their own programs. As such, the key indicator of project success is the successful completion of the individual RAP-financed activities. This is appropriate, not only for this type of project, but also for the conditions that currently exist in Afghanistan. However, the key indicator of project success remains whether agricultural productivity and rural incomes have increased as a result of the project. This requires that A.I.D./Rep have some indication of the critical constraints to increasing agricultural productivity and rural incomes inside Afghanistan, and some way of assessing whether RAP activities have had an impact on these constraints. A.I.D./Rep does not have this capacity at this time.

Recommendations:

- A.I.D. Rep consider preparing annual work plans jointly with IRC/RAP. These work plans would be based on identified constraints to increasing agricultural productivity and rural incomes in Afghanistan, and used as a basis for measuring progress in achieving the project purpose.
- A.I.D. Rep prioritize project outputs to reflect purpose-level targets and communicate these priorities to IRC and the PVOs so that they are reflected in the subject approval process.

5. What is the appropriate RAP management structure taking into account the type of activities funded by RAP and A.I.D./Rep staffing constraints?

The present management structure is based on the cooperative agreement between A.I.D./Rep and IRC. The strengths of this arrangement are that IRC/RAP greatly reduces the administrative burden on A.I.D./Rep, and most short-term activities which RAP is designed to fund are relatively quickly approved by RAO/Peshawar and the A.I.D./Rep grants officer. The major flaw is that IRC does not have the technical capability to substantively manage the project. The result is a cumbersome approval system with PVOs not able to obtain direct answers to substantive questions without dealing directly with A.I.D./Rep. The approval system is further confused by the lack of coordination between RAO/Peshawar and A.I.D./Rep in Islamabad.

Recommendations:

- IRC should be given responsibility for substantive review, management, and independent in-country monitoring of routine subgrants, and should be provided with the necessary staff to carry out this responsibility. Since these tasks are substantially different from IRC's main program with Afghan refugees, the IRC/RAP staff should be established as an autonomous unit similar to the IRC/ UNOCA mine awareness program.
- All routine subgrants as described in the report should continue to be approved by RAO/Peshawar and the A.I.D./Rep Grants Officer.
- All agricultural activities with longer-term development objectives should be reviewed and approved by the ADO. If implementation is to be managed and monitored by the ADO they should be funded through direct grants. If IRC/RAP is to have this function, they should be funded under the cooperative agreement.

PART TWO
THE PVO CO-FINANCING PROJECT

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SECTION ONE

INTRODUCTION

In 1986, the office of A.I.D./REP, through the health sector of its PVO Co-Financing Project, began funding a number of PVOs to provide Pakistan-based medical training for Afghans. These PVOs made it a policy of limiting enrolment in their training programs to Afghan trainees recommended by mujahideen commanders based inside Afghanistan. The trainees agreed to return to Afghanistan upon completion of the training and work under the supervision of their sponsoring commanders. The PVOs responded to the urgent needs of an embattled rural population having no medical support by developed relatively short training programs ranging from six to sixteen months.

In the fall of 1987, A.I.D./Rep undertook the first evaluation of these PVO training programs (Hunte, et al., 1987). At that time, the first classes of medical trainees had only recently graduated and little information on the activities of the trainees was available. The evaluation team concentrated on a description of PVO training programs with detailed description of course admission criteria, curriculum and methodology, education administration, and monitoring and evaluation activities. The overall conclusion of the team's report was that PVOs were capable of training appropriate mid-level health personnel to work inside Afghanistan. The recommendations of the evaluation team underscored the need for coordination and standardization in the training programs.

Two years have passed since the initial evaluation of the PVO medical training programs for Afghans. During that time, the number of health workers in Afghanistan has increased dramatically. Now, according to a database maintained by the World Health Organization (WHO) in Peshawar, more than 5,000 health care providers are currently being supplied with medicines in Afghanistan. While some regions are still poorly served and others are suffering from poor distribution of resources, most areas of Afghanistan currently have limited access to medical assistance.

Increasingly, with the help of monitoring reports and the debriefing of program graduates, PVOs are realizing that, in addition to their ongoing training activities, they must now begin to concentrate their efforts on retraining and upgrading skills of training program graduates. In addition, PVOs have realized that they must now make a determined effort to consolidate existing health care providers so that all present and planned clinics have two or more health workers under one clinic roof. It is in the context of this maturing medical relief effort for Afghanistan that the present evaluation is being conducted.

The primary aim of this evaluation will be to determine the degree to which PVO training programs have been able to document and respond to the challenging requirements of medical care delivery in Afghanistan. The present evaluation also examines the progress that PVOs have made towards cooperation in standardizing their policies and implementation strategies in order to assist in the development of a sustainable health system for Afghanistan. Specific reference to training program design will be presented only if it was not covered in the 1987 evaluation, or if there has been substantial change from that described previously.

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SECTION TWO

PVO PERFORMANCE

The PVO Co-Financing Project supports the medical training and related activities of six PVOs and the coordinating activities of the CMC. Approximately 75 percent of project funds obligated in FY89 were granted directly to three American medical PVOs: Mercy Corps International, Freedom Medicine, and International Medical Corps. For this reason, and with the encouragement of the A.I.D./Rep health staff, the evaluation team concentrated their attention on these PVOs, giving particular priority to an analysis of Freedom Medicine's proposal to transfer their medical training activities to the Ministry of Public Health of the AIG.

In the following section, the three American health PVOs are discussed at length, as well as CMC and its potential role in the future of the A.I.D./Rep health program. The European health PVOs funded under the project -- the German Afghanistan Committee (GAC), Medical Training for Afghans and the Medical Refresher Course for Afghans (MTA/MRCA) are reviewed briefly.

MERCY CORPS INTERNATIONAL

Background

Mercy Corps International is an American organization with headquarters in Portland, Oregon; its Afghanistan activities are based in Quetta. MCI began its program of medical assistance for Afghanistan in 1986 with mid-level medical training of Afghans and provision of medical supplies and salaries for their program graduates. They also provide financial support for the construction and operation of their facilities in Afghanistan. To date, 119 Afghans have graduated from MCI's six-month training course and 99 of these graduates are currently staffing MCI's 3 hospitals, 23 clinics, and 15 mobile units in Afghanistan.

MCI is unique among PVO's providing training for Afghans because it has worked closely with a group of Afghan physicians who, prior to MCI's presence, had already established a hospital and training program. This Quetta-based group, Jamiat-al-Ulama, allowed MCI to use its Al Jihad outpatient and inpatient facilities in return for financial and material support for the hospital. The Jamiat-al-Ulama physicians continue to run their three-month training program essentially independent of MCI.

One of the recommendations of the 1987 evaluation was to combine the MCI and Jamiat training program so that the three-month course could be condensed into a one-month first-aid course to prepare trainees for an intensive six-month course. MCI recognized the wisdom of this recommendation, especially since the three-month course graduates were being given far more medications than they could responsibly administer. However, consolidation of the programs was not acceptable to the Jamiat-al-Ulama physicians. Nevertheless, MCI has succeeded in gradually decreasing the number of medicines provided to Jamiat-al-Ulama's trainees. In fact, the Jamiat-al-Ulama physicians have altered their course curriculum to emphasize first-aid and preventive health. Medications are not discussed in the course nor are medical supplies given at its completion.

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The Training Program

The MCI mid-level training program is divided into two parts. The first has a curriculum of theory plus clinical skills development. The second has a curriculum that focuses on one area of specialty training per student, either outpatient (OPD), dental, laboratory, x-ray, operating theatre, or ward nurse.

The core curriculum, initially covered in three months, has been expanded to five months. MCI's reason for lengthening the core curriculum was that, after debriefing a significant number of returning graduates, it became clear that, regardless of what one might call specialty training, in Afghanistan, in all graduates were called upon to provide direct patient care in the OPD setting.

Now, during the final three months of special training, all categories of workers get at least two weeks of outpatient clinic training with the OPD student spending all three months in the outpatient clinic under the direct supervision of MCI Staff. The scheduling of the full eight months is comprehensive. All daily schedules are prepared prior to course commencement.

Health Services in Afghanistan

MCI currently has two surgical hospitals inside Afghanistan. These facilities are designed to have an inpatient ward of 10 to 20 beds, a small surgical suite, and an outpatient clinic. In addition to a doctor with surgical experience, there is laboratory, x-ray, dental, ward nursing, and outpatient support staff.

The MCI outpatient clinics (OPD) are categorized according to the level of training of the personnel that staff them. A clinic in category OPD-A has at least one OPD worker, one dental worker, and one worker with laboratory training. The OPD-B has at least one OPD worker and one dental worker. The OPD-C has at least two workers, one of which is an OPD worker. MCI currently supports 10 OPD-A clinics, six OPD-B clinics, and seven OPD-C clinics.

The lowest level of service, the mobile units, are made up of at least two first-aid workers and they are equipped with a motorcycle for rapid response to emergencies in the field. They normally work in conjunction with a fixed clinic to facilitate patient disposition.

Future Plans

MCI recently closed its facilities in the area surrounding Herat and in northwest Afghanistan due to problems with double supply of medicine, political instability, and the difficulty of supplying and monitoring these facilities. It plans to concentrate its medical program in southwest Afghanistan. While consideration had recently been given to creating 16 new clinics along the border with Pakistan, MCI has chosen to emphasize the upgrading of existing facilities. Its goal is to complete a surgical facility in Kabul, which lacks only a surgeon, and to upgrade its OPDs to level A. Seven mobile units operating in the vicinity of Kandahar are no longer needed and will be phased out. The other eight mobile units located in the southwest will be upgraded to permanent facilities.

MCI is currently proposing a pilot study for tuberculosis treatment in Baghman, Helmand. This is an area controlled by a commander who apparently has demonstrated a concern for the health of his people. He has taken all the TB medications off the local market and is giving responsibility for treatment solely to the MCI facility in Baghman. A monitoring team visited the facility in June of this year and noted that

the doctor and nurse at the facility were treating TB and felt there is a high incidence of TB in the area. The clinic had a well-equipped laboratory, an x-ray machine, and a doctor/nurse team interested in the treatment of TB. These factors, plus a controlled catchment area supported by a strong commander, suggested the potential for TB treatment in Baghman.

There were, however, several major deficiencies noted in the TB treatment program in Helmand. Specifically, there was no reliable data on the actual incidence of TB in the area. Of greater concern was the fact that there were no standard treatment guidelines being followed nor was there an adequate reporting and recording system or follow-up of treatment. Also absent was an outreach component necessary to conduct the door-to-door monitoring of compliance with treatment.

Of the deficiencies noted above, the one of greatest concern is the proven ignorance of the medical staff in the principles of running an effective TB treatment program. Since the program will be only as good as the discipline and organizational skills of the program directors, this program does not appear to have great potential.

As part of its planned TB pilot study in Helmand, MCI has contracted with the Agence Internationale Contre le Faim (AICF), a Paris-based teaching resource experienced in the development of outreach workers. MCI and the Quetta-based Afghan PVO Health Unlimited (HU) have jointly contracted AICF to train eight HU village workers as well as seven MCI outreach workers from the Baghman.

MCI is also considering the implementation of an outreach health worker program to replace the current three-month basic health worker (BHW) training course. This course would also be taught by AICF and would emphasize preventive health in addition to TB and malaria control. These workers, as opposed to the BHWs, would be assigned to a clinic, and the existing clinic personnel would have supervisory responsibility. The outreach workers would receive a salary from MCI and their medications would be restricted to acetaminophen and aspirin.

Recommendations for MCI:

- Strengthen expatriate recruitment through concerted home office efforts including, but not limited to, contacting graduate programs in public health.
- Improve student clinical skills by early (within one month) exposure to diagnosis and treatment of patients in the OPD setting.
- Consult with the Italian Cooperation for Development (ICD), the Peshawar-based specialists in TB among Afghan refugees, on the feasibility of conducting a TB treatment program in Helmand. The current medical staff would have to undergo extensive retraining or MCI would have to recruit a competent TB program director.
- Retrain and upgrade the existing skills of clinic personnel to include instruction in supervisory skills and an understanding of the potential function of outreach workers that may eventually come under their supervision.
- Delay implementation of an outreach program at least until existing personnel can be briefed on the program.
- Consider reducing the number of students trained in laboratory techniques, shortening their training period to two to three months and placing them only in facilities that will fully utilize their services.

- Focus the training program on retraining the first two MCI classes and the nurses working for MCI (but not trained by MCI), as opposed to training new providers.
- Incorporate into training, as much as possible, the practical realities of working in Afghanistan, especially clinic organization and structure.
- Increase the length of training programs to one year.

FREEDOM MEDICINE

Background

Freedom Medicine is an American group based in Washington, D.C. It has been involved in the training of mid-level Afghan health workers since 1986. Freedom Medicine's six-month training program is conducted at a hospital complex that it constructed in the Pakistani village of Thal near the Afghan border. The setting for the training facility and the structure of the facility itself were chosen specifically to simulate the working conditions that trainees would encounter in Afghanistan. Training course curriculum is evenly divided between medical and surgical illness with an emphasis on clinical exposure.

The expatriate management of Freedom Medicine has recently decided to gradually withdraw from the training and allow Afghans to play an increasing role in their own training. While Freedom Medicine has fully integrated Afghan physicians into the implementation of its training program, the management feels that it should go one step further and prepare for the transfer of Freedom Medicine facility and programs to the Ministry of Public Health (MOPH) of the Afghan Interim Government. Accompanying this planned transfer of training resources to the AIG, commonly referred to as the "transition," Freedom Medicine has developed a policy to provide refresher training and supplemental education to graduates of training programs rather than continue training more mid-level health workers. The training course graduates currently being supported by Freedom Medicine would also become the responsibility of the Ministry of Public Health.

The Proposed Transition

The Educational Program

August 1989 marked the graduation of Freedom Medicine's last class of mid-level health workers. Shortly thereafter, Freedom Medicine began curriculum development for a new three-month advanced medical training program designed to upgrade the current medical skills of its trainees, and to provide supplemental education with an emphasis on primary health care and preventive medicine. Both the Afghan doctors who have previously taught in Freedom Medicine's training program and Freedom Medicine's expatriate staff have worked jointly on the developing the new curriculum. Emphasis has been placed on using a competency-based approach to teaching stressing the importance of active learning -- learning by doing rather than listening -- and identifying essential skills rather than teaching theoretical knowledge. The Freedom Medicine Afghan staff is also taking a course for trainers currently being conducted by the expatriate staff.

With the beginning of this curriculum development, Freedom Medicine created a transition team made up of members of the Freedom Medicine's own expatriate staff and members of the MOPH. At the time of the team's formation, three Afghans from

the MOPH were placed on the Freedom Medicine payroll. The transition team has identified three major areas in the development and transfer of the advanced training program: (1) curriculum development, (2) recruitment policy, and (3) training.

Curriculum Development

The general outline for the curriculum has been produced and is made up of both new information and material for review. The curriculum will require a total of approximately 150 hours teaching time with approximately two-thirds of that time devoted to re-training and review, and one-third devoted to new material.

General topics for review come under the headings of normal anatomy and physiology, history and physical exam, the management of wounds, and the review of body systems, with emphasis on the diagnosis and treatment of common diseases. New material focuses on clinic management, community and preventive health, and a deeper understanding of pharmacology coupled with its practical application. These topics are appropriate for the intended level of health worker, and the increased emphasis on community health is both needed and desired by health workers inside Afghanistan. Individual topics are presented in a competency-based training format, emphasizing skills and abilities rather than theoretical knowledge.

The sections of the curriculum reviewed were not of a consistently high quality. Those that closely comply to the ideals of competency-based training are of high quality. Other sections where the objectives are ill defined, unrealistic, or difficult to measure are understandably weaker. The accompanying text for these headings has yet to be written, except for the "Growth and Development" section. The text was complex and quite theoretical.

Generally speaking, the choice of material for this level of health worker re-training is appropriate. The teaching methodology, using the competency-based training, is an excellent means of presenting this type of information. While there were some very successful applications of this format within the curriculum, it needs to be applied consistently to all material. The practice of keeping the material on a demonstrable and practical level must also be borne in mind when writing the text that accompanies these subject headings.

Recruitment

The admission criteria used by Freedom Medicine for past training programs will also be used for the advanced training course. In addition, candidates must have completed six months of training and at least six months of medical work in Afghanistan. An entrance exam will constitute the major barrier to acceptance into the program. This exam, yet to be developed, will require serious consideration and time commitment. Once developed, it should undergo a number of trials before acceptance. The challenge will be to determine the minimum level of student knowledge and skills acceptable for retraining and then to design the exam to identify that level.

Training

Instructors for the advanced training course have not yet been selected. They will be Afghans, but the numbers of those coming from Freedom Medicine and those coming from the MOPH has not been discussed. The only instructor who will definitely participate is Dr. Rabani Popol from the MOPH who will teach the course "Supervision in Medicine," a section he developed and has taught before. It is likely that the Afghan physicians working at Freedom Medicine who have been involved in the

development of this curriculum would also be included in the teaching process. The subject of future employment, however, has apparently not been discussed with the Freedom Medicine Afghan staff. Dr. Fatimi, Head of Training for the MOPH, announced at a recent gathering in Thal that the Afghans on Freedom Medicine staff were welcome and needed in the ministry. However, in a conversation that took place during this evaluation period, Dr. Fatimi said that he would be responsible for finding trainers. The issue of future instructors for this course needs clarification.

The Advanced Training Program and the Cost of Transition

The added costs of transferring the training program from Freedom Medicine to the MOPH should be minimal. One significant expense is the transition team itself, made up of one full-time and one half-time expatriate and three Afghan physicians from the MOPH.

Eight physicians will be required to run a training program of 16 to 20 students with two overlapping courses. This is the current number of Afghan physicians employed at Freedom Medicine. Assuming that the MOPH will pay salaries comparable to those of Freedom Medicine and MOPH, training staff costs should remain constant. If the Afghan staff at Freedom Medicine are integrated into the majority of the instructor positions, the transition process should be relatively smooth and costs minimal. The greater the number of staff hired from the MOPH, the longer the time it will take for the transition because new staff will be unfamiliar with Freedom Medicine's expatriate teaching style. The consequent increase in overlap between expatriates and Afghans would result in increased cost.

One potentially significant cost that has not been discussed is the salary of health workers who complete the advanced training course. If these health workers continue to be supported by their present sponsors -- Freedom Medicine and the Swedish Committee for Afghanistan (SCA), an important PVO in the cross-border health field -- there will be no increased costs. However, if the MOPH desires to fund these individuals on its own, there would be an ever increasing cost associated with successive training programs.

The Time-frame for Transition

Once the training program begins, the transition team feels that the MOPH could be running the program at the end of the first six months. The target date for the first class is January 1990. Given the critical importance of curriculum design and its preliminary stage of development at this time, January is an optimistic goal. With a course duration of three months and a second course scheduled to begin six weeks into the first course, at the end of six months, four classes will have graduated. However, if programs do not overlap and only one program is conducted each three months for the first several courses, a six-month training period would permit only two classes to graduate during the same six-month period. This latter approach, conducting only one class at a time during the early phase of course implementation, though probably lengthening the period of transition, would increase the likelihood of an orderly transition.

The Transition Process: Freedom Medicine Mid-Level Graduates

Another component of its program that Freedom Medicine intends to transfer to the MOPH is the responsibility for the supply, salaries, facility support, monitoring and debriefing of graduates of Freedom Medicine's earlier mid-level training program. Freedom Medicine currently supplies salaries and facility support for their graduates while SCA supplies their medicines. No new expenses can be foreseen unless the SCA is unwilling to continue supplying medicines to these graduates after they come under the aegis of the MOPH. No formal agreement has been made between Freedom Medicine and the SCA to ensure continued supply of medicine to Freedom Medicine graduates after the transition process. Since the financial burden of supplying medicines to more than 150 graduates is significant, this arrangement must be confirmed as soon as possible.

Conclusions

The planning for the transfer of Freedom Medicine's developing advanced training course and responsibility for their past program graduates to the MOPH of the Afghan Interim Government is proceeding according to plan. The tremendous need for re-training and supplemental education of graduates of middle-level training programs is widely recognized. Freedom Medicine is the first PVO to begin work on this important issue. The current expatriate medical staff is both dedicated and competent. The content and emphasis of the course is appropriate for the needs of a returning health worker. The training materials produced so far are not consistently high quality but they are still in draft form. The final product has the potential to be very good. The competency method of training is an effective means of presenting the information.

Assuming that the material preparation for the course is successful, program implementation is the next issue. Unfortunately, no decision has been made about who will teach the mid-level curriculum. If the MOPH decides it wants to teach the majority of the course, there would be two reasons for concern: (1) Dr. Rabani Popol is the only experienced teacher in the Ministry, and (2) The Ministry plans to start its own one-year medical technicians course in the next three to six months. In terms of instructor selection, the MOPH course would probably take precedence over Freedom Medicine's. In addition, should the MOPH move their one-year training course to the Freedom Medicine facility at Thal, this move would probably compromise, if not destroy, the advanced course by severely limiting the trainees' clinical exposure. An effective solution to these issues would be for the training program to have a majority of its instructors drawn from Freedom Medicine staff with a smaller contingent from the MOPH.

In discussions with Management Sciences for Health (MSH), the A.I.D./Rep health sector support project contractor, it became apparent that they were largely unaware of what was transpiring between Freedom Medicine and the MOPH. MSH's major training interest is in the MOPH's upcoming one-year course. There is, thus, no indication that MSH would attempt to bolster Freedom Medicine's advanced course if it began to falter after the transfer to MOPH.

Contingency Plans

If the proposed transfer of Freedom Medicine's operations to the MOPH should fail, certain aspects of the Freedom Medicine program would be sustainable. Specifically, if the advanced training program curriculum is of high quality, it could be used by other programs interested in instituting and upgrading a supplemental component of their overall program. With regard to the past graduates of Freedom Medicine's training program, SCA may be willing to pick up their salary and facility support costs, and take on responsibility of monitoring their work.

If current funding levels for training were to be scaled back, funding priorities would have to be established. Top priority should be given to supporting a high quality retraining program, the FM advanced course. Support of graduates of the Freedom Medicine training program who continue to demonstrate competency should also be continued. Funding cuts should be focused on consolidating existing health facilities and personnel with particular emphasis on facilities manned by solitary health workers. Large numbers of such health units are difficult to supervise, impossible to control and ultimately, are unlikely to be incorporated into a future health system.

Recommendations for Freedom Medicine:

- Increase the size of the transition team to include an Afghan physician from its own training program.
- Delay the advanced course opening one to two months to ensure that the curriculum, text, and practical sections are of consistently high quality.
- Conduct only one class during the first three-month period to avoid confusion during course implementation.
- Consider including a section on dermatology and pediatrics, two commonly mentioned areas of weakness for returnees.
- Finalize an agreement with the Swedish Committee for Afghanistan to ensure that SCA will be willing to continue to supply medicines to past Freedom Medicine graduates after the transfer of training activities to the MOPH.
- In the event of funding reductions, reduce the number of clinics by consolidating clinics of single health care providers into clinics of greater capacity.

INTERNATIONAL MEDICAL CORPS

Background

International Medical Corps is an American PVO with headquarters in Los Angeles; its Afghanistan-related activities are based in Nasir Bagh on the outskirts of Peshawar. IMC's principal activity has been training Afghans for health care delivery in Afghanistan.

IMC has graduated five classes from its eight-month training program. These 200 graduates are working in 41 clinics and four hospitals supported by IMC in Afghanistan. IMC pays the salaries for these workers while SCA supplies graduates with medicines.

Training

The IMC training program began with a strong surgical emphasis but has evolved to more accurately reflect the health care needs of both civilians and mujahideen in Afghanistan. The current goal of IMC's training program is to produce a graduate who is capable of correctly diagnosing and treating approximately 80 percent of the diseases that he will encounter in Afghanistan.

The present curriculum is well designed to serve this purpose. The time allotted to the classic divisions within medicine (surgery, medicine, pediatrics, and so forth) is

appropriately balanced to cover the common diseases in Afghanistan. There has been a recent increase in emphasis on community health and a new section on clinic management. Both these changes are based on the results of monitoring and debriefing of graduates.

Sixty percent of course time is spent on theory with the remaining 40 percent being practical or clinical experience. The first five weeks of the training program are devoted to the teaching of theory. After that, students spend half days in clinical training. During the three clinic hours, groups of two students are supervised by one instructor each. Each student sees approximately one patient per hour to instill a comprehensive understanding of the process of taking patient history and conducting a physical. By the end of the course a student may see up to five patients during a three-hour session. In addition to the standard medical core curriculum and practical experience, the IMC student is introduced to simple techniques in dentistry as well as the basic laboratory techniques.

In addition, IMC, in conjunction with the French PVO Afghanistan Vaccination and Immunization Centre (AVICEN), has trained several teams of vaccinators and has successfully conducted a vaccination program funded by the United Nations International Children's Fund (UNICEF) in Afghanistan.

Future Plans

IMC is interested in developing a three-month advanced training program beginning in the spring of 1990. Class size would be limited to 30 students chosen from IMC's first three basic training classes. Retraining is currently conducted on an informal basis according to the requests of the returning graduate. IMC has not yet developed the curriculum for an advanced course.

IMC has submitted three proposals to WHO. One proposal is for a lab technician training course. A second is for an Afghan clinic construction project using Shelter Now, a Peshawar-based PVO, as a consultant. The third, and most significant, is a proposal for an Afghan physician retraining course. The details of the retraining have not been worked out, but the course would be headed by two former IMC instructors and most of the training would be conducted in existing Afghan hospitals throughout Peshawar. These two individuals were not in Peshawar at the time of the evaluation, and it is not known if they have made contracts or even formal contacts with the Afghan facilities.

Conclusion

IMC's curriculum and training program is very strong. However, it could benefit from an increase in the proportion of practical versus theoretical exposure for the trainees. The clinic facility itself is more sophisticated than those found in Afghanistan. A clinic designed more along the lines of the type IMC is building in Afghanistan would provide the students with a learning environment that more closely approximates true field conditions. Such a facility would complement the newly added clinic management section of IMC's training course.

The design of the clinical section of IMC's training course allows the trainee to see only up to five patients over a three-hour period. This is less than a moderate-to-busy clinic inside Afghanistan. Ideally, by the time the student finishes his course, he should have experienced the patient load comparable to what he will see inside Afghanistan. He would then learn how to function under the pressure of increased patient load while still under supervision.

Recommendations for IMC:

- Increase the percentage of practical versus theoretical teaching in their training course.
- Increase the length of its training program to one year, emphasizing the basic clinical skills of history taking and physical exams.
- Place the highest priority of new program implementation on refresher training and upgrading of skills. Seriously consider retraining early graduates by enrolling them in the full one-year course on a trial basis.
- Construct a clinic facility for outpatient care that simulates actual field conditions in Afghanistan.
- Study the impact of laboratory results on patient care. Specifically, how often do the laboratory tests taught at IMC substantially change treatment. This can take the form of research, comparing what would have been prescribed on the basis of history and physical alone versus what was prescribed after the results of the laboratory test. The results of such a study would help answer the question of whether laboratory testing under the rather rudimentary medical conditions in Afghanistan is appropriate.

GERMAN AFGHANISTAN COMMITTEE

Background

The German Afghanistan Committee is a Bonn-based organization with its field headquarters in Peshawar. GAC has supported a small number of Afghan-operated medical clinics in Afghanistan since 1984. There are currently 13 of these clinics located in eastern and central Afghanistan. This number has remained fairly constant over the past three years as new clinics have been opened to replace those that were discontinued. GAC also supports an Afghan-run training and treatment facility at Sadda, in the Pakistani tribal agency of Kurram, close to the Afghan border.

No GAC quarterly reports were available to the team for review. GAC management evidently provides their reports directly to Bonn and not to A.I.D./Rep. The management did provide the team with data on the clinics that GAC supports. Additional information was obtained through discussions with the new medical director, a doctor with extensive GAC experience in Afghanistan. GAC is not a member of CMC.

Findings

The 13 health centers supported by GAC vary widely in terms of staffing and physical plant. Shera Khana in Wardak Province has an eight-member medical team including two doctors and two nurses. This clinic has a large inpatient facility and OPD as well as accommodations for staff. The staff sees approximately 12,000 patients over a six-month period (on average, 76 patients per day) and has incurred medicine expenditures of \$92,000.00 over a six-month period. In contrast is the GAC facility at Zadran, in Paktitka Province, a first-aid and OPD facility with one nurse and three support staff. The staff at Zadran sees an average of 62 patients per day and spends \$20,000.00 for a six-month supply of medicine.

Nine of the 13 GAC facilities are headed by Afghan doctors, and all medical personnel are supposed to spend at least eight months per year at their respective clinics. GAC has attempted to recruit doctors to head the four clinics currently run by nurses. Recruitment difficulties have been encountered when medical personnel acceptable to the constituencies of each clinic have not been endorsed by GAC's Afghan co-director.

German medical teams visit the clinics supported by GAC for varying lengths of time, providing medical care and demonstrating techniques of health care delivery to clinic staff. There is no formal didactic schedule, although each team identifies one topic to present during their clinic stay. In 1988, seven such teams entered Afghanistan. In 1989, only one team entered Afghanistan. This team was led by a German orthopaedic surgeon who spent three-and-a-half months working in a number of clinics. This doctor reported that he was disturbed by some of his experiences, particularly the reluctance of Afghan physicians to learn from his example and suggestions.

GAC has experienced a sharp decline in the number of expatriates that it has been able to field over the last few years. This reflects both a decline in funding and, most certainly, a lapse of Afghanistan interest in Germany since the withdrawal of Soviet troops. As a result, both the training and monitoring capacity of GAC has suffered.

GAC clinics incur disturbingly high drug expenses. For example, the \$100,000 bill for six months supply of medicines submitted by the GAC staff of their Sher Khana clinic compares unfavorably to the \$6,000 incurred by the staff of the central hospital at Rocha, in the Panjshir Valley, supported by SCA for the same period of time.

Recommendations for GAC:

- Use the independent medical monitoring activities offered by other health PVOs.
- Take advantage of Peshawar-based retraining opportunities for its Afghan medical personnel working in Afghanistan.
- Join CMC and adopt the standard drug list employed by all members.

MEDICAL TRAINING FOR AFGHANS AND MEDICAL REFRESHER COURSE FOR AFGHANS

Background

Medical Training for Afghans is the collaborative effort of Aide Medical Internationale (AMI), a Paris-based PVO and the Belgian group Solidarité-Afghanistan that began in Peshawar in 1984. MTA offers a 16-month program designed to train Afghans to a level of "physician's assistant," or, in other words, to function autonomously in a rural clinic or in a hospital under a physician's supervision. To date, 53 students have graduated from the MTA course. Upon graduation, trainees are supplied with medicines and salaries from either SCA or MSH.

Medical Refresher Course for Afghans was formed in 1986 to provide a surgical facility and services in Pakistan for Afghan war wounded, and to use the facility to upgrade the training of Afghan doctors and nurses already working in Afghanistan. MTA's early efforts to improve the anesthesia and surgical skills of Afghans were

largely abandoned because of their inability to recruit sufficient students with an adequate medical background and motivation to responsibly apply these skills.

Findings

The teaching potential of MRCA has been fully realized in providing its students with practical surgical experience in wound and post-operative care. In addition, students rotate through anesthesia and dentistry training sessions to supplement their core theoretical and clinical training. Laboratory training is limited to the preparation of slides. Students also have exposure to physiotherapy and the use of prosthetics through the training activities of the Sandy Gall Fund staff who are housed in the same facility as MTA and MRCA.

To improve the teaching ability of MTA instructors, the organization hired an education consultant in the fall of 1989. The consultant conducted a one-month course in teaching methodology and testing. According to the MTA instructors, this course was beneficial and provided them with a more systematic approach to their training.

MTA's training program is significantly longer than that of other PVOs. Its training environment is medically sophisticated, surpassing some of the services provided by district health facilities in Afghanistan before the war. The training provided by MTA makes their graduates more suitable for working in a hospital environment.

MRCA has had extensive experience in teaching the principles and practices of anesthesia and surgery to Afghans who have had limited exposure to medical practice. The evolution of their approach to this type of training represents an important source of training information. A written description of this evolution would constitute a useful practical guide when such training is needed in the future.

Recommendations for MTA and MRCA:

- MTA should insure that the skills of their graduates are utilized maximally by attempting to place them in more sophisticated medical facilities in Afghanistan.
- MTA should examine the Freedom Medicine advanced training course to determine if their own graduates would benefit from advanced training after having worked in Afghanistan. Regardless of the decision, MTA should identify the areas in which their graduates require retraining.
- MRCA should consider preparing a document describing the evolution of their teaching method and practical training of anesthesia and surgery to nonphysician health providers.

COORDINATION OF MEDICAL COMMITTEES

Background

The Coordination of Medical Committees (CMC) began in 1985 as an informal gathering of cross-border groups to discuss communication and coordination issues among themselves. By late 1986, this multinational group recognized the need to institutionalize itself. In 1987, with funding from A.I.D./Rep, CMC hired a medical director and an administrator. By the winter of 1988, CMC's membership included all the major PVO organizations involved in cross-border medical activities. CMC's members include AVICEN, Freedom Medicine, Medecins du Monde, German Afghanistan Committee, IMC,

Medecins sans Frontieres, MTA, MCI, the Norwegian Committee for Afghanistan, and the Swedish Committee for Afghanistan.

The first task undertaken by CMC was to analyze the data held by each member agency on a total of approximately 50,000 patient visits conducted in Afghanistan. The most significant finding of this analysis was that trauma, including war injuries, accounted for less than five percent of all clinic visits. This finding had an important impact on later development of training program emphasis among the member agencies.

By the summer of 1988, CMC members agreed to follow a standardized list of drugs and a common scale for health worker salaries. In addition, the members of each agency contributed to the preparation of a therapeutic manual of common diseases found in Afghanistan, which outlined standard treatment protocols acceptable to all members. Members have also cooperated in providing information to each other on the location of their clinics in Afghanistan. This information is being mapped by CMC administration.

At this point, individual members began to realize that more accurate information was needed regarding their medical activities inside Afghanistan. CMC was felt by its members to possess the collective expertise necessary to implement effective expatriate medical monitoring in Afghanistan. As a result, CMC initiated a number of independent monitoring missions. The first two missions were completed in the fall of 1988 and there have been three subsequent missions.

When ACBAR was formed in the fall of 1988, CMC member agencies discussed the possibility of CMC assuming the role of a forum for cross-border activities within the medical subcommittee of ACBAR. CMC remained active in the area of standardization during this time by providing guidelines for defining the function of low-, middle- and upper-level medical provider in Afghanistan. These definitions were in the form of a skills list identifying clinical disease that each level of worker should be able to diagnose and treat.

In the spring of 1989, CMC as a group agreed to disband itself into the medical subcommittee of ACBAR. Concurrent with that decision, however, ACBAR began to question its own function as an implementing or coordinating organization. CMC members then retracted their decision in favor of remaining a separate committee concerned exclusively with cross-border medical assistance. Since that time, CMC has pursued its three main functions: monitoring, mapping of medical facilities, and assessing the utility of the green book as an administrative and diagnostic tool.

The three successful missions sponsored by CMC to monitor clinic facilities in Afghanistan identified the green book reliability as a major problem. Approximately 50 percent of the books were felt to be unreliable because of practices such as pre-entering patients or filling out the green books at the end of the month. It was apparent that health providers saw the green book solely as a ticket for resupply. It is clear that, during their training programs, the CMC members must emphasize the green books as a reference during patient follow-up visits. There is ongoing discussion at CMC whether the green book should be reformatted and, if so, in what form.

CMC and its members also participate in meetings held by WHO and ACBAR to standardize definitions for various types of clinics. These definitions, coupled with a certification exam for the various levels of health workers, are prerequisites for establishing major systems of health care.

Findings

CMC has contributed significantly to cooperation and standardization among health PVOs. In addition, it has implemented a medical monitoring program, the first of its kind, that produced a large body of potentially useful information. The achievement of this level of coordination in an organization of some 10 members from five separate nations with no contact in the field is admirable.

CMC has concentrated on medical monitoring in 1989. While a tremendous amount of information was presented in the monitoring reports, the member organization responses to the results have been mixed. The CMC members with training courses have been very positive, but those undertaking other activities did not feel the reports were of much use. Both responses are understandable. The general monitoring reports were very informative for the trainers and have been instrumental in changing program emphasis. There are, however, other elements that could be abstracted from these reports which could have direct impact on the medical structure inside Afghanistan.

Poor distribution of facilities and personnel in Afghanistan should be addressed by the organizations in regions of concern. Jaghato, Wardak is one such area identified by medical monitoring, where more than 11 clinics and one hospital serve a population of between 35,000 and 40,000 (Saenave & Paulson, 1988a). The organizations supporting these facilities should, after careful consideration of the medical and political consequences, agree to consolidate facilities or redistribute facilities and personnel.

New clinic construction should also consider medical and political factors along with the population density, present, anticipated and existing medical resources of the area, and potential patient referral patterns. Much of this information is contained in the monitoring reports.

The future role that CMC will play in standardization is unclear. WHO and, to a lesser extent ACBAR, are currently most active in this area. The CMC members are active in both organizations and may prefer that these issues be decided outside of CMC. The current Executive Director for CMC would prefer that CMC focus on monitoring, but the CMC Board has yet to meet to discuss next year's proposal. Regardless of the decision, CMC should be prepared to address the needs of its members. In this light, CMC should elicit suggestions of how it might serve the needs of CMC members who do not have Pakistan-based training programs. These members have participated in, and offered financial support to CMC, but have received little in return.

Recommendations for CMC:

- Review and abstract all CMC medical monitoring reports to identify trends or facts that affect medical training or field operations.
- Revise the monitoring questionnaires so that they will give definite answers to specific questions; identify questions whose answers can be coded for computerized database entry.
- Consider hiring a short-term consultant with expertise in monitoring field projects and questionnaire development.

SECTION THREE

PROJECT DESIGN

PROJECT OBJECTIVES: QUALITY VS. QUANTITY

There are presently over 5,000 health workers in Afghanistan according to the WHO database. SCA supports, but did not train, 2,000 health providers. MSH has trained and supports 1,650 health worker graduates of its three-month training course. Among themselves, the PVOs have trained and supplied over 500 health worker for Afghanistan. While not all those who have been trained or supplied are actually delivering health services in Afghanistan, there are nonetheless thousands of low- to mid-level trained health workers, each equipped with several hundred medicines and taking care of patients without supervision or control. A prewar point of reference is the fact that there were 138 Basic Health Units in Afghanistan in 1979 (O'Connor, 1980).

Quality of Training Programs

The overall quality of the cross-border medical training programs supported by the PVO Co-financing Project is good. In the past three years, the curricula have evolved to reflect the reality that, despite the horror and occasional preponderance of war injuries, the medical problems of Afghanistan during the war are essentially the same as those of the prewar era -- problems of public health and primary health care. Reference material developed by PVOs for their training programs has drawn heavily on the concepts pioneered in *Where There is No Doctor* and has also profited from the exposure each organization has had to medical field conditions in Afghanistan. As a result, practical training no longer includes the placement of chest tubes or performance of amputations, the latter procedure having been wisely replaced by debridement and general wound care. The resultant educational framework prepares the health worker with far more appropriate skills today than was the case three years ago.

However, most training programs fail to accurately reproduce those conditions in which the health provider will work in Afghanistan. The outpatient facilities used in training programs should be designed to more closely approximate the standards of a basic clinic inside of Afghanistan. Clinic models based on both expatriate and Afghan experience in Afghanistan are available.

Also, health PVOs introduce a degree of sophistication in material and personnel support that is not warranted according to feedback from the field. Donated generators provide light for evening tea, and autoclaves gather layers of Afghan dust. That same dust covers microscopes, some costing as much as \$800 each. One explanation for why the health worker is not using his microscope is that he has no time to perform laboratory studies. While in some situations this may be true, results of monitoring show that there is a general lack of use of this equipment regardless of clinical activity. With the need to maximize the teaching of useful information and skills, the training programs owe it to themselves, their students, and their donors to demonstrate the impact of laboratory testing on the management of common illnesses in Afghanistan.

For those PVOs that are determined to train laboratory technicians, consideration should be given to recruiting from the large pool of present-day medical practitioners who were laboratory technicians before the war, many of whom are identified in the detailed monitoring reports prepared by CMC (see bibliography). The retraining of these

individuals and their placement in facilities large enough to fully utilize their services would accomplish two things: (1) the reinstatement of qualified laboratory technicians and, (2) the reduction of the number of health providers who have had minimal training in curative or preventive medicine.

Quality of Program Graduates

Medical monitoring and debriefing indicate that the level of health care provided by graduates of the PVO short-term (6 to 16 months) medical training courses is, given the current situation in Afghanistan, acceptable. These graduates are able to identify the correct organ system and, if the patient has a condition that requires drug treatment, the drugs prescribed usually cover that condition. There is, however, a marked over-prescription of medications, particularly antibiotics. The route of drug administration chosen by the PVO-trained health provider is generally appropriate, whereas monitors noted an alarmingly high use of injectable medications by the minimally trained health worker.

The diagnostic ability of the PVO-trained provider was limited primarily by superficial history taking. Incomplete physical exams were also observed. The graduates acknowledged their limitations and were unlikely to prescribe potentially dangerous drugs from the bazaar pharmacies. This latter practice was too often observed among the Basic Health Worker provider.

The Need for Retraining

The most common and urgent request from training program graduates is for retraining. Some graduates were trained up to three years ago, and all realize their inadequacies and want to advance their knowledge. Of all groups, it is the graduate of the first two to three classes in each program (total number approximately 175 to 250) who are most ardent in their appeal for more training. The PVOs have realized the need for this retraining but have been too occupied with improving the core of their programs to formally address this need. The programs have accommodated, to the degree possible, the wishes of the returning graduates for more exposure in specific areas of their concern.

No training program has conducted a formal upgrading and retraining course. Freedom Medicine, which recently closed its mid-level training program, is closest to achieving this end. They are developing a three-month advanced training course with hopes of implementing it early next year. The course is open to graduates of six-month courses other than Freedom Medicine.

When fully operational, the Freedom Medicine program will have the capacity to retrain a maximum of 150 students a year. With over 500 graduates from the PVO programs and new graduates still being produced, it would require more than four years to retrain these people.

Conclusion

PVOs have recognized the value of quality over quantity in their health worker training programs but this realization has not been fully put into practice. While they realize that increasing the length of their training courses would be of significant benefit to future trainees, the solution to improving quality of past graduates is through retraining. The majority of PVO health providers were trained during the time when the PVO training strategy was to prepare medics working under conditions of war. PVO interests were surgical and their orientation was curative. After working in the

field, PVOs have come to realize the importance of primary health issues and are anxious to learn more about them. Information derived from monitoring and debriefing indicates that graduates need strengthening in their ability to assess patient complaints and to arrive at a reasonable diagnosis. The graduates of the early courses were found to be the weakest, a fact attributable to both the attrition of knowledge over time and the relative weakness of the early courses.

A strong argument can now be made for limiting PVO training activities to the retraining of former program graduates. Priority should be given to the early graduates of the training programs. MCI has instituted a policy of retraining personnel in existing MCI clinics in preference to training new personnel.

A realistic target for the PVOs is a program graduate who has been retrained to fit a role similar to a physician's assistant but with added public health awareness. This type of worker would be viable and worthy of sustaining until a health system evolves that can absorb him.

THE ROLE OF PVOS IN THE AID/REP HEALTH PROGRAM

Strengths and Weaknesses of the Health PVOs

Many of the same strengths and weaknesses of PVOs as project implementors described under the RAP section are applicable to the medical PVOs supported by the Co-financing project. There is a high level of commitment among PVO staff which creates enduring links between the PVOs and the local authorities in Afghanistan with whom they work. Because of their close links with the field, PVO staff have a good understanding of the medical requirements of the populations that they serve and the conditions under which they must operate. The medical PVOs are decentralized and maintain a low profile in the field, which provides them with flexibility to respond to many types of medical situations. For example, Freedom Medicine was able to respond quickly to Commander Jalaluddin Haqani's request for emergency medical assistance during the bombardment of Khost in 1987.

Still, PVO staff members are often underpaid and not sufficiently qualified for the work that they are required to perform. These conditions often result in high levels of staff turnover, management problems, and lack of continuity in ongoing programs.

Regardless of these drawbacks, the medical PVOs represent an important dimension to the overall AID/Rep health program for Afghanistan. In the absence of an effective government in Afghanistan, health PVOs provide vital training services and support to medical practitioners throughout the country under conditions that make the development of centralized health care impossible. Perhaps more than any other type of PVO, those that concentrate on health have shown a willingness to cooperate in the standardization of training programs and field operations.

PVOs and Management Sciences for Health

To a large extent, medical PVOs play a complimentary role to that of Management Sciences for Health (MSH), the A.I.D. health sector project contractor, in the AID/Rep health program for Afghanistan. The explicit goals of the health sector project at its inception in 1986 were to assist the then Alliance of Afghan Mujahideen Health Committee (AHC) to improve the general health care for both civilian and military populations, improve critical medical and surgical facilities for war casualties, and improve the capability of the AHC in planning and managing expanded health activities and in

training health providers. MSH, through its project activities, continues to pursue these goals through its attempts at institution building within the Ministry of Public Health (MOPH) of the AIG, the successor to the AHC.

Since 1986, MSH has assisted the AHC/MOPH in graduating 1,650 Afghans from a 12-week Basic Health Worker (BHWs) training program. Graduates are expected to be able to identify and treat common illnesses on their return to Afghanistan, and, upon graduation, they are provided with antibiotics, medical supplies, and salary.

Unlike the PVOs, which are currently scaling back the number of trainees they accept into their programs to upgrade the level of training quality, MSH continues its basic BHW training strategy with the goal of graduating a total of 2,500 BHWs. While MSH attempts to meet the pressing need for basic health services throughout Afghanistan, the PVOs are attempting to develop a body of middle-level health providers who may make a more enduring contribution to the development of a health care system in Afghanistan.

Many of the health PVOs are skeptical of the utility of the BHW and do not endorse MSH's goal to continue this level of training. They maintain that large numbers of medical practitioners with limited training, limited exposure to the treatment of women and children, and a propensity to provide or prescribe dangerous drugs, are actually a liability to the development of a health system in Afghanistan.

The A.I.D./Rep health office should consider the perspective of the PVOs in determining the direction of their health program in Afghanistan. Greater consideration should be given to the improvement of training programs, and to the improvement of the accountability and supervision of program graduates in the field, to increase the chances of these practitioners being incorporated into a national health care system.

COORDINATION

Background

PVOs providing cross-border medical assistance to Afghanistan realized the importance of coordination from very early on. Coordination originally took place on an informal basis and was later institutionalized in the form of CMC. In CMC, these PVOs have met together at length to discuss their respective activities and to identify common issues. Out of this initiative has come a standard drug list, a therapeutic manual with protocols accepted by all members, a relatively standard salary scale for health care workers, and the only independent project monitoring effort in Afghanistan.

Findings

Progress has been made in standardization and coordination but much remains to be done. Now that PVO efforts -- the training of health providers, the support of health facilities and the supply of medicines -- have reached levels beyond those that existed before the war, there is an urgent need to reassess the present and future medical needs in Afghanistan. It is no longer appropriate to send countless health workers and large supplies of medicines across the border. On the contrary, there needs to be an increased control over these practices and an uncompromising selection process identifying unacceptable health practitioners and nonessential health facilities. To determine and enforce the standards necessary to accomplish will require tremendous cooperation and coordination.

One major constraint to the coordination of activities is the shortage of staff within each of the PVOs. Simply put, no staff member of any health PVO has enough time to process the information available on the training and field practice of Afghan health practitioners. Both the CMC monitoring reports and the WHO database represent valuable sources for this information. Productively used, these resources could assist health PVOs in identifying and locating the most effective health practitioners in Afghanistan and in determining ways to support them (for example, with surgical capacity and laboratory training and equipment) to build a greater regional health capacity. Similarly, this information can be used to identify poorly performing health practitioners, or to identify clinics with small constituencies that can be either weeded out or consolidated with more effective facilities. Such a continuous evaluative process is essential for developing a sustainable health system in Afghanistan.

Recommendations:

- For each of the health PVOs funded under the Co-Financing Project, A.I.D./Rep should consider funding a position for a staff member dedicated exclusively to coordination. That staff member would have responsibility for attending all CMC, WHO, and ACBAR coordination meetings. In addition, that staff member would be responsible for analyzing both internal and independent monitoring reports and making recommendations to management for maximizing field resources.

MONITORING

The monitoring of cross-border health activities is every bit as problematic as that described for the monitoring of RAP-supported projects above. The difficulties are compounded by the number of trainees that need to be monitored, the mobility of the trainees, and the limited capacity of a single monitoring team to locate a representative number of trainees during a single mission from which to draw sufficient information for an evaluation of training programs.

A number of health PVOs have developed a system of debriefing their medical trainees during each trainee's routine returns to PVO headquarters for resupply of medicine. Debriefing by PVO medical staff permits qualitative monitoring of trainee performance, though at a distance from actual field operations. The following section discusses the monitoring and debriefing methods of MCI at length. These are perhaps the most sophisticated methods of any of any of the health PVOs.

CMC has played an important role in developing standard monitoring formats for PVO field monitoring missions. CMC's actual monitoring activities have been discussed at length above in the PVO performance section.

Mercy Corps International

The monitoring of MCI health facilities in Afghanistan has increased significantly in the past year. Most of this monitoring has been done by Afghans who have no medical background and hence is termed nonmedical monitoring. The function of this type of monitoring is to verify the existence of health facilities and the presence of staff. Medical, or qualitative, monitoring of staff performance at MCI clinics was carried out for the first time this year by a CMC monitoring team.

All MCI medical facilities were monitored last year. Nontechnical monitoring was performed by both MCI and a Swedish Committee monitoring team. The medical monitoring of facilities was conducted by CMC as well as a newly formed MCI team.

The MCI medical monitoring team is composed of two recent graduates of the MCI training program who were unable to go back to their region. During a five-week orientation, they learned to use the CMC monitoring form and rotated through the hospital and clinic to familiarize themselves with the equipment and functions of these areas. Four monitoring missions of two-week duration each covering an average of five clinics per trip were completed.

MCI management feels that the results of these monitoring missions have put them in a better position to assess and improve on the medical care provided in their facilities. The CMC information was particularly helpful when the team stayed long enough to provide an indepth evaluation of the facilities. Some clinics were monitored by several different teams and their independent reports have served to check the reliability of all monitoring data.

Debriefing

The debriefing of medical providers returning to Quetta for resupply is being increasingly recognized as a extremely important source of information. This method has undergone significant evolution at MCI over the past year and there is now a well-delineated debriefing process for returning health care workers.

The returning health care provider fills out a debriefing form when he arrives at the MCI training facility in Quetta. This form requires factual information describing clinic location, staff composition, types of patients seen at the clinic, and services provided, as well as identification of any problems with supply of medicines. The returnee is then examined orally by a expatriate physician whose chief responsibility is debriefing. The oral exam, which lasts from two to three hours, is designed to test a returnee's ability to diagnose an illness and prescribe the appropriate treatment. The test consists of a list of approximately 50 common diseases along with their symptoms and treatment which is jumbled. These descriptions of diseases and the treatment were abstracted from the CMC Therapeutic Manual and thus were available to the student during his training. The results of the quiz are placed in the returnee's file along with his initial debriefing form.

The "green book," used by all PVO medical trainees to record their daily OPD diagnosis and treatments, is reviewed by MCI staff with the returning health worker to identify misdiagnosis or mis-treatment. When these are noted, they are discussed with the returnee. If a significant deficiency is identified, or if the individual is interested in a period of retraining, he enters a relatively informal and brief program of retraining at MCI's facilities. It should be noted that MCI is aware that the green books often do not accurately reflect actual patients seen. Nevertheless, MCI still feels that the green book review is a worthwhile exercise to emphasize the health trainee's accountability, and to review purported treatment practices.

Recently, MCI introduced a new element in the debriefing procedure to evaluate the use and accuracy of laboratory testing for malaria. The returnee is instructed to identify positive smears and bring them to Quetta for confirmation. There has been only one returnee with slides to date, and only three of the eight that he brought were readable. All three were positive for malaria.

The Impact of Monitoring and Debriefing

The impact of monitoring and debriefing can be most clearly demonstrated by the number of clinics where operations were terminated on the basis of the debriefing forms. During the past 18 months, MCI has suspended eight of 42 of its facilities in Afghanistan. Specific reasons for suspension included double (and sometimes triple) funding by various donor organizations, and the nonexistence of clinics or personnel. Only one termination resulted from a debriefing where a physician, reportedly a graduate MD, was found to be at the level of a first aid worker. MCI-trained providers found at the time of debriefing to be deficient were usually only marginally so, and reportedly responded well to retraining.

MCI's system of debriefing is an excellent one. The creation of a staff position dedicated to debriefing was instrumental in the system's development. The debriefing form, which allows for documentation of the returnee's response to the questions of how he both describes and treats the common illnesses, provides a reference point with which subsequent debriefings can be compared.

One addition to the debriefing procedure that would increase its ability to assess the quality of the returnee is the implementation of a standardized clinical examination. After completion of the written portion, the debriefing would move to the outpatient clinic where the graduate would be observed as he performs a history and a physical exam and gives instructions to three to four consecutive patients. A written form should be developed to document whether or not all critical actions were taken.

Freedom Medicine

Freedom Medicine has carried out monitoring for in-country verification purposes since 1987. This monitoring has been performed by nonmedical, Dari-speaking expatriate and Afghan monitors. In addition to verifying the presence of health providers, the monitors record general impressions regarding clinic function and make suggestions for improving Freedom Medicine's support of its trainees.

Formal medical monitoring of FM facilities has been performed principally by CMC monitoring missions. One of Freedom Medicine's former instructors participated in the CMC monitoring mission to southern Afghanistan.

Freedom Medicine's monitoring was suspended this past summer due to budget constraints but, at this writing, it has reportedly resumed. In coordination with CMC, Freedom Medicine has trained Afghan monitors who will use a multiple choice questionnaire, which it has developed itself with the assistance of the director of CMC.

Debriefing is another source of information used by Freedom Medicine to evaluate their graduates and the conditions under which they work. Freedom Medicine has tended in the past to place more emphasis on nonmedical issues than some other groups. This is at least partially due to the fact that the Freedom Medicine staff has been located at some distance from Peshawar and have found it difficult to interview all returning graduates. Now that Freedom Medicine's medical director is based in Peshawar, this problem should be alleviated.

International Medical Corps

IMC has a well-developed, nontechnical monitoring system. Much of site verification takes place at the time of delivery of medicines at clinic sites. In-country monitoring questionnaires are filled out by a total of 20 Afghan nontechnical monitors and returned to IMC Peshawar for analysis. IMC recently sent their first medical

monitor, an Afghan physician, to visit the IMC clinics. The IMC medical questionnaire is composed of open-ended questions that concentrate on the medical practice of the IMC graduate and, to a limited degree, the quality of his diagnostic skills. IMC clinics have also been monitored by the CMC expatriate medical monitors.

The debriefing of returning graduates is done both by the Afghan and expatriate staff. The medical debriefing attempts to identify deficiencies but no written record of these deficiencies is made. The green book is often not available during the debriefing session. At the time of debriefing the student indicates areas where he feels deficient. IMC then accommodates him by providing him with refresher training in those areas of weakness.

German Afghanistan Committee

GAC expatriate medical teams have served a monitoring function through their periodic visits to GAC clinics in Afghanistan. These teams have observed inadequacies among the Afghan staff (for example, absenteeism and inappropriate medical diagnoses and treatments) but are often frustrated in their attempts to affect change. One concrete result of a team visit was the closing of a GAC clinic in Wardak after it observed an overabundance of clinics in that area.

GAC has chosen not to participate in the independent expatriate monitoring offered by CMC, and its clinics have not been formally monitored by any other health PVO.

Medical Training for Afghans

MTA has concentrated a good deal of effort on medical monitoring. It has supported four separate monitoring missions by AMI personnel to Afghanistan. MTA graduates were also monitored during one of the CMC monitoring missions. Nonmedical monitoring is reportedly performed by SCA and MSH, the two groups that provide medical supplies and salaries to MTA trainees. To date, 23 MTA trainees (43 percent of all trainees) have been monitored. Seventeen were found to be present and working in their designated clinics.

The most recent MTA monitoring efforts have focused on covering a small number of clinics for greater lengths of time. The intent of this approach is to provide on-site clinical teaching and to assist the MTA trainee in setting up his clinic. MTA management is pleased with the initial results of this in-country monitoring and sees mutual benefits for both teachers and graduates.

MTA's debriefing process is similar to that described for IMC. However, MTA staff do use the green book in the debriefing process and report that this method is helpful in identifying weaknesses in both diagnosis and treatment. The debriefing staff requires retraining of graduates who are found to have gaps in knowledge. Additional training is optional for all graduates.

Coordination of Medical Committees

Much of CMC's activities during the past two years has concentrated on monitoring. During this period, CMC has supported three successful monitoring missions that generated seven separate reports. CMC member organizations participate in the planning of the monitoring missions and the debriefing of the monitors, who are not affiliated with any of the member organizations. CMC monitors are technically qualified to undertake qualitative as well as quantitative monitoring of health facilities and staff.

As indicated in the description of CMC performance above, the monitoring reports have been well received by CMC members and have been useful in the development of both training programs and clinic operation.

SUSTAINABILITY

The issue of developing a sustainable health system was beyond the initial scope of the PVO Co-financing Project. The primary objective of the PVOs in health was to provide emergency care to the civilian population of Afghanistan. The objective has largely been achieved. In fact, there are now more health care providers and medical supplies in rural Afghanistan than before the war. These providers, however, are usually low- to mid-level trainees working in relative isolation, without supervision, indigenous supplies, or financial support. There is as yet no health system to sustain them.

Health systems development has been to a large extent impossible due to the lack of regional political stability. The two exceptions to this are in the northeast with the Shura-i-Nazar, and the Herat region with the Amirate of Ismael Khan. In these regions, health systems are developing to exert some control over the allocation of medical supplies and the types of services (such as surgery) that health workers are allowed to provide.

All medicines provided by PVOs are free to the people in Afghanistan. The workers providing care are handsomely supported, again from outside sources. This degree of support for health will never be sustainable by an Afghanistan government alone. Nor is such a level of support desirable. The evaluation team feels that the time has come to gradually decrease the amount of funding currently allocated for supporting lower-level health providers. The result could be a desirable degree of consolidation in health services.

The most viable product of PVO training programs will be the better trained health care provider capable of functioning with a degree of autonomy in the rural health care setting. Though a system of supervision should develop over time, the doctors who have recently left the cities can be expected to return to the cities when the fighting is over. It is likely that the rural health center will remain the domain of the qualified mid-level health worker.

SECTION FOUR

SUMMARY OF MAJOR FINDINGS AND RECOMMENDATIONS: PVO CO-FINANCING

The goal of humanitarian organizations involved in providing medical assistance for Afghanistan should be to maximize their positive impact on health care in Afghanistan. In the absence of epidemiologic data, impact measurement is difficult. For programs training Afghan health workers to work inside Afghanistan, the best measurement of program success is the number of health workers produced who provide ongoing quality health care in Afghanistan. Ultimately, success will be determined by the program's contribution to a permanent Afghan health care system.

The most valid criteria currently available to assess impact is through independent in-country medical monitors. Despite their shortcomings, medical monitoring reports have been invaluable in one respect: they have consistently identified the same major issues of concern regarding health services in Afghanistan. These issues can be grouped under three headings: (1) the need to limit the number of health care providers, (2) the need to increase the quality of providers, and (3) the need for coordination and standardization in health care delivery.

THE NUMBER OF HEALTH CARE PROVIDERS

The compelling need for large numbers of health care workers is over. WHO reports that support is being provided to over 5,000 health workers for medical care in Afghanistan. The SCA supports approximately 2,000 health providers, MSH supports 1,650 providers, and the PVOs have trained over 500. These health workers are functioning in a situation where there is no control, no supervision, and no health system. Medicines can be found throughout Afghanistan, and though health care workers may complain about lack of medicines, monitors assess this to be a problem of massive overuse rather than undersupply. Medical treatment administered by PVO-trained health providers (six to 16 months) was determined to be acceptable but limited by the students' marginal skills in clinical diagnosis. The performance of workers trained for shorter periods of time was considerably worse and often dangerous. An encouraging finding was that all levels of providers expressed a strong desire for further training. They realized their limitations but were often forced to practice beyond their limits because of patient pressure or the need to save face.

QUALITY OF HEALTH CARE PROVIDERS

The demand and need for upgrading the skills of program graduates is tremendous. Over 500 health care workers have been trained by the PVOs and none has received formal, comprehensive retraining. PVOs state that retraining is a priority but, except for Freedom Medicine, none has developed a formal retraining course.

From a practical standpoint the quality of teaching, organization, curriculum, and reference material has improved to such a degree over the past three years that, if graduates of each PVO's first class were to come back, they would think they were in a completely different course. MCI has made it compulsory for their first class graduates to retrain.

COORDINATION AND STANDARDIZATION

Standardization within the health care sector is another pressing need and is a prerequisite for development of a sustainable health care system. PVOs have made considerable progress in the area of standardization. The Coordination of Medical Committees has served as a forum for cooperation and production of standard drug lists, a standard text for the diagnosis and treatment of common diseases in Afghanistan, a standard monitoring questionnaire, and relatively equitable salaries for health workers. Using the CMC text as a guide, CMC and WHO have developed a minimum skills list for low-, middle-, and upper-level health providers. Much remains to be accomplished. The skills list must be transformed into an exam that can delineate these various levels. Ultimately, health care providers will be certified according to their skills and knowledge. WHO is the appropriate body to perform the certification both because it has credibility, having served in this capacity elsewhere in the world, and because of its projected long-term involvement in health issues in Afghanistan. ACBAR, relatively inactive in the medical field, may be called upon to define standards for laboratory and x-ray technicians.

Definitions must also be developed for facilities in Afghanistan. The meaning of "clinic" ranges from a solitary mobile worker to an inpatient facility with minor surgical and laboratory capabilities. Just as optimum treatments were identified, so must optimum clinic composition be determined. For example, what is the minimum service and personnel requirements to serve an outpatient population of 50 patients per day? As increasing amounts of information are provided by monitoring missions, facilities can be categorized and upgraded, down-sized, or consolidated to fit a standard category.

The development of health systems in Afghanistan is not possible in areas of political or military instability. Only crude systems of referral can be found in these areas. Political stability must be achieved, as it has been in the Shura-i-Nazar region, before attempting to set up a true health system.

A coordination issue of lesser significance is the question of whether the green book, the patient record used inside Afghanistan, is of value. For epidemiologic purposes, the analysis of data from health providers at random is useless. Monitoring has shown that greater than 50 percent of the books are probably invalid. Analysis could be done, however, on green books of health workers who have been monitored and are felt to be reliable.

AFGHANIZATION

The subject of Afghanization of organizations is increasingly discussed among the PVOs. Within PVO medical training programs, this has largely taken place with Afghan physicians currently in high, if not director level, positions within the training programs. Health PVOs see their role as temporary and are ready to turn over their programs when they are no longer needed. However, if Afghanization means to fold a program into the MOPH, most PVOs are reluctant to do so at this time. To date, the MOPH and its predecessor, the Alliance Health Committee, have not demonstrated a capacity to implement projects that are respected by the PVOs. It is the MOPH and other Afghan physicians in Pakistan who must Afghanize the PVOs, making their presence known and felt in a positive way with their people in Afghanistan.

The MOPH is still young and there are some signs that suggest it will be more active than the former Alliance Health Committee. The MOPH recently conducted a monitoring mission in Wardak that returned with an informative report and MOPH staff

are presently identifying sites in Afghanistan for permanent teaching facilities called satellite health centers.

RECOMMENDATIONS

- PVO medical training programs for Afghans should be at least one year in length and the numbers of trainees should be reduced.
- PVO training programs need to develop and implement a retraining and upgrading course of at least three months that will be held regularly throughout the year.
- AID/Rep should fund Freedom Medicine to develop and implement an advanced medical training program for Afghans.
- The Coordination of Medical Committees should be supported in its function as a forum for coordination, and as an appropriate organization for conducting independent health monitoring in Afghanistan.
- AID/Rep should request a follow-up evaluation in 18 months. The Scope of Work should include all A.I.D.-funded medical programs for Afghanistan and emphasize impact evaluation.

PART THREE
CROSS-SECTORAL, PVO-FUNDED ACTIVITIES

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Parts One and Two of this evaluation deal with issues that have to do with each of the A.I.D.-funded PVO projects. Part Three considers overall issues in A.I.D. support of PVO programs in Afghanistan. These issues fall into two categories: (1) What is the role of PVO programs in the overall A.I.D. program, and (2) How should support for PVO programs be managed to assure the achievement of A.I.D. objectives.

SECTION ONE

THE ROLE OF PVOS IN THE A.I.D. PROGRAM

INTRODUCTION

When the U.S. government started the cross-border humanitarian assistance program in 1985, the only organizations able to operate inside Afghanistan were PVOs. Most of those already working in Afghanistan were European PVOs providing health care, food aid, and cash-for-food. The United States funded these organizations and encouraged American PVOs to undertake similar programs inside Afghanistan. At present, A.I.D. is providing financial support to seven American PVOs and eight non-American PVOs.

During the last two years, A.I.D.'s focus has shifted from emergency relief to rehabilitation and development. Not only have the PVOs been encouraged to move in this direction, but major sector programs have been initiated and are being implemented inside Afghanistan by direct A.I.D. contractors. These sector programs differ from PVO programs in two important respects. First, the funding levels, scale of activity, and potential impact are much larger. Second, PVO programs are designed, implemented and controlled by the PVOs themselves, whereas the sector programs are designed by A.I.D. and implemented by contractors under the direct control of the A.I.D./Rep office. The issue facing A.I.D. at this time is how to fit support for PVOs into an A.I.D. program that is becoming more developmental and is made up increasingly of activities designed by A.I.D. and implemented by A.I.D. contractors. The factors to be considered in addressing this issue are discussed below.

THE STRENGTHS AND WEAKNESSES OF A.I.D.-FUNDED PVOS OPERATING IN AFGHANISTAN

The main strengths of the PVOs presently receiving A.I.D. funding are clear from the previous sections of this report. They are a high level of commitment, good contacts inside Afghanistan, and low operating costs relative to other implementing organizations. Although, as will be discussed below, their reasons for being in Afghanistan differ widely, the main objective of their activities is simple and straightforward -- to provide relief and humanitarian assistance to Afghans. Many of the European PVOs have been in Afghanistan since the early 1980s. The staff of all PVOs are young and energetic. They travel willingly inside Afghanistan under difficult and dangerous conditions, and have a strong commitment to establishing effective working relations with the people they are assisting. As a result, they have a good knowledge of local needs and working conditions and have good relations with local authorities.

Although there is a wide variation in the capabilities of PVOs currently being supported by A.I.D., their main weaknesses are inexperienced management, lack of technical expertise, lack of development experience, and high staff turnover. These shortcomings are directly linked to the low funding levels provided by PVOs. Their staff are

mostly young and inexperienced, and those that are older are usually experienced in professions not directly related to the programs for which they are now responsible. The result is that most PVOs do not have the expertise to address complex development problems, and do not have strong project planning and implementation capabilities. Low salaries assure rapid staff turnover that perpetuates the inexperience and in turn limits PVO effectiveness.

This leads to the conclusion that PVOs should be utilized for projects that require close local contacts and are not technically or managerially complex. In the health area, PVOs are appropriate for supplying medicines to clinics and providing basic health training. Under the PVO Co-Financing Project, PVO health training programs have been particularly effective because the trainees are selected by the communities to which they will be returning, and the training programs are kept simple and aimed at the specific needs of rural clinics. These PVOs are not qualified to provide high-level health training or to set up national or regional health delivery systems. In the agriculture area, USAID-funded PVOs are well suited for identifying and implementing simple relief and rehabilitation projects but, with two exceptions (MCI and SCF), not for implementing agriculture projects that involve new technologies or raise complex processing or marketing issues.

THE ISSUE OF DIFFERING PVO AGENDAS

The two PVO projects support 15 PVOs working in Afghanistan. Some are well established and operate worldwide (for example, CARE and SCF); others have been established specifically to assist the people of Afghanistan. A common characteristic of all of these organizations, however, is that the orientation and content of their programs is determined by their founders, boards of directors, or both. Each organization has a distinct history and set of priorities, usually political (anti-communist) or humanitarian, that set it apart, not only from other PVOs but also from the donor agencies and the governments of the countries in which they operate.

For A.I.D., this means that support for PVOs constitutes a special type of assistance program. Normally, A.I.D. designs an assistance program jointly with the host government and hires a contractor to implement the program. In the case of PVOs, A.I.D. and the host government assess the PVO program as designed by the PVO and decide whether it contributes to their common objectives. If the decision is made to fund the PVO, neither A.I.D. nor the host government, in this case the AIG, can exercise direct control over implementation. If, after the fact, performance proves to be unsatisfactory, A.I.D. has the option to discontinue funding.

This arrangement causes problems for A.I.D., the AIG, and the GOP. It is fair to say that the GOP is highly suspicious of PVOs and merely tolerates their involvement in the Afghan program. The GOP assumption is that PVOs are providing assistance to Afghanistan for their own reasons and have no particular commitment to the political objectives of the U.S. government, the GOP, or the AIG. Consequently, the GOP has not facilitated the work of PVOs in Afghanistan and, as discussed earlier, has in fact hindered them in obtaining visas and transporting materials through the tribal areas into Afghanistan.

The AIG has been less obstructive toward PVOs. Most PVOs keep the AIG informed of their activities but do not consider it necessary to obtain their prior approval, and certainly do not design their programs to bolster the AIG. At best, PVOs feel that the AIG does not have the capacity to coordinate assistance activities inside Afghanistan. At worst, they do not consider the AIG to be the official government of Afghanistan and are therefore unwilling to be associated with it. PVOs are in general agreement that AIG sponsorship of their programs would be a hindrance

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rather than a help in most areas of Afghanistan. The official AIG position is that PVOs are welcome because their activities help Afghans. Also, most factions within the AIG do not want the PVO programs terminated because they benefit politically from activities that are implemented through local authorities with whom they are affiliated. However, there is little doubt that the AIG would prefer all A.I.D. assistance to be channelled through its ministries as is the case for the sector programs.

For the A.I.D./Rep Office, the PVOs present three problems. The first is that, by being committed first and foremost to their own ideals, they cause resentment among influential Afghans who feel that PVOs are not sufficiently concerned with the goals and priorities of the Afghan people. Thus A.I.D. is in a position of funding programs that tend to strain relations rather than strengthen political ties. Second, funds channelled through PVOs do not directly support the AIG, which is a major U.S. policy objective. This is in contrast with the sector programs which are closely identified with the AIG.

Third, from the A.I.D./Rep Office's standpoint, the PVO programs lack commitment to institution building. The PVOs are in Afghanistan in response to perceived emergency needs and simply want to achieve the short-term objectives of their programs in the most effective way possible. Their primary commitment is to meet the immediate needs of their target populations, not to train or organize Afghans to meet those needs over the long-term. PVOs do hire Afghans to meet staffing requirements, but they see this as a means to an end, not as a major objective of their programs.

The A.I.D./Rep Office's perception of PVOs is essentially correct. When the PVOs were brought into the Afghanistan program, there were no alternatives. Although they could not be depended on to further all of the political and development objectives of the A.I.D. program, they did have the capacity to meet the specific objectives of the cross-border humanitarian assistance program as described in the original PVO co-financing activity approval memorandum (AAM) and the subsequent RAP AAM. This continues to be the case. However, now that A.I.D./Rep has alternatives to PVOs, it must decide whether, despite the shortcomings described above, PVO programs are an essential element in the overall A.I.D. program and should be continued, or whether they should be phased out and, where possible, replaced by sector programs being implemented by A.I.D. contractors. As will be discussed below, how A.I.D./Rep answers this question will help determine how the office should approach the management of its PVO co-financing program.

THE ISSUE OF ABSORPTIVE CAPACITY

The issue of absorptive capacity presents itself in two contexts. The first has to do with the health activities. As noted in Part II, there are too many clinics, low-level health workers, and medicines inside Afghanistan. There are considerably more clinics in Afghanistan than there were before the war. Many of these clinics are staffed only by low-level health workers who are unable to provide satisfactory health care without proper supervision. In many cases these health workers actually have a net negative effect on health conditions when they routinely distribute inappropriate medicines to patients. Under these circumstances, there is a need to cut back rather than increase certain types of assistance to the health sector.

For A.I.D., this raises the issue of whether to continue supporting the existing programs of health PVOs. The evaluation team found that programs to train additional basic health workers and open new clinics should not be funded, except in remote areas that have not yet been reached by existing programs. This means that future funding of health PVOs must be accompanied by a reorientation of their programs away from increasing numbers of clinics and workers to increasing quality. The need now is for

better staffed clinics and more highly qualified health workers. If the PVO programs continue as they have, there is an absorptive capacity problem and there should be a reduction in funding. If, on the other hand, PVOs reorient their programs toward improving the quality of health care, there is a continuing need for financial support. The PVOs are aware of this need and, as noted above, have begun reorienting their programs.

The problem of absorptive capacity also arises with respect to the RAP. In this case, the issue is excessive funding relative to the implementation capacity of the PVOs. The evaluation team found that all of the RAP-funded PVOs are either receiving funds from other donors, mostly U.N. agencies, or are in the process of applying for such funds. PVOs feel that there is no shortage of funds for well-designed relief and rehabilitation or rural development projects.

The availability of excess funds creates the danger that PVOs will become overextended, with the result that all of their programs suffer. This problem is not unique to Afghanistan. In many developing countries, available funds exceed the number of sound, fundable projects. One solution is to cut back funding. Another is to be more selective in the criteria for funding so that funds are made available for the particular activities that are critical to or at least consistent with the overall objectives of the A.I.D. program. The evaluation team feels that, even if there are abundant funds for rural development activities, a well-managed RAP will make an important net contribution to the rehabilitation of rural areas in Afghanistan.

CONCLUSION

PVOs are an asset to the A.I.D. program, but only for very specific types of activities. The PVOs currently being funded by A.I.D. can carry out simple relief and rehabilitation activities, train mid-level health workers, and support health clinics as or more effectively than alternative implementing organizations, in this case A.I.D. contractors, and at lower cost. PVOs do not have a comparative advantage in longer-term development projects such as multi-year agricultural development projects or setting up a national health delivery system. A.I.D. must also accept that PVOs are not likely to contribute significantly to the strengthening of the AIG and do not have a strong interest in the Afghanization of their programs or in long-term institution building in general.

The PVOs have obvious shortcomings but they are making important contributions to the humanitarian objectives of the A.I.D. program. Since much of what they achieve is based on the commitment of their staff and their local contacts, their programs could not be easily replaced if they were terminated. This argues for continuing support for PVOs. However, their role in the overall program must be carefully defined, well understood, and accepted by the A.I.D./Rep Office. Otherwise, A.I.D./Rep will continue to be generally dissatisfied with their performance and will see them more as a necessary evil to be tolerated until a better alternative comes along than as a valuable component of the overall A.I.D. program. An adversarial relationship makes it difficult for A.I.D. to manage its PVO program effectively and constructively.

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SECTION TWO

A.I.D./REP MANAGEMENT OF PVO PROGRAMS

THE EXISTING SITUATION

Much of the existing management system for the PVO programs evolved in response to urgent needs as they arose during the hectic early years of the program. The PVO Co-Financing Project is based on a brief AAM that does not adequately describe the objectives and priorities of the program but provides wide flexibility in the types of activities that can be financed. Since most of the early recipients of A.I.D. support were non-U.S. PVOs, a cooperative agreement with an intermediary organization (a U.S. PVO) was set up to channel funds to PVOs who would otherwise have been ineligible for A.I.D. funding. Under the cooperative agreement, the only responsibility of the intermediary institution was to account for the expenditure of A.I.D. funds.

Later, U.S. PVOs began receiving funds under the Co-Financing Project. These PVOs were funded through direct grants rather than through the cooperative agreement. In 1988, the A.I.D./Rep Office designed a second PVO project, RAP, which was given more of a development focus. Cash-for-food and emergency grants were transferred to RAP, leaving only health activities in the Co-Financing Project. When RAP was designed, it was decided to channel all grants through an intermediary institution under a cooperative agreement primarily to reduce the administrative burden on the A.I.D./Rep staff.

The end result of these changes is that there are now two projects and three different management arrangements for the PVO program. Support for U.S. PVOs in the health field is provided through direct grants managed by the A.I.D./Rep health staff in Islamabad. Support to non-U.S. PVOs in the health field is channelled through a cooperative agreement in order to meet U.S. legal requirements, but the individual grants are reviewed, approved, and managed directly by the health staff. Grants to both U.S. and non-U.S. PVOs under RAP are made through a cooperative agreement and jointly managed by the intermediary institution and RAO/Peshawar.

The RAP objectives and major activities are fully described in the AAM and the project is managed by A.I.D./Rep on the basis of that document. The Co-financing AAM, however, provides no corresponding description of the objectives and activities being funded in the health sector. Consequently, there are no officially approved objectives against which to measure progress under the Co-Financing Project. The approach being followed by A.I.D./Rep is to manage PVO health activities in the context of its overall health sector strategy and objectives.

The next section examines possible changes in the approval documents and management arrangements to help assure the maximum contribution of the PVO programs to the overall objectives of the A.I.D. program in Afghanistan.

REQUIRED CHANGES IN THE MANAGEMENT OF PVO PROGRAMS

The systems to be used in managing the PVO program should be determined primarily by the nature and complexity of activities to be managed. The types of activities currently underway or about to be undertaken are:

- Grants to address emergencies caused by war or natural disasters;
- Grants for the rehabilitation of rural infrastructure and small-scale distribution of agricultural inputs;
- Larger-scale agricultural production projects;
- Grants to train health care providers and support rural health clinics; and
- Grants to promote democracy and pluralism.

The first three types of grants are being funded under RAP, and the last two under the Co-Financing Project. All five types could be combined into one project for funding purposes. This would require a new project paper which discusses the objectives of each category of grant and describes activities that would be eligible for funding. Regardless of whether or not the PVO programs are combined into one project, the health activities, the rural rehabilitation activities, and, to a lesser extent, the agricultural development activities cannot be effectively managed unless they are redesigned as separate subprojects. The purpose, outputs, and recommended management systems for each of these subprojects are discussed below.

The PVO Health Program

Purpose: To provide basic health care to Afghans in rural areas.

Outputs:

1. Revised training programs aimed at upgrading the skills of low- and mid-level health care providers.
2. Continued support for rural health clinics in Afghanistan.
3. Development and application of standardized qualifications for each level of health care provider.
4. Development and application of standard minimum staffing and equipment standards for rural clinics.
5. The development of improved systems to monitor the quality as well as the quantity of health care being provided in PVO-supported clinics.

There is no officially approved funding document that describes the PVO health program in this way and places these activities in the context of the overall health sector program. This should be done as soon as possible to facilitate the effective management of the PVO program.

Management System:

A.I.D./Rep support for PVOs in the health sector consists of annual grants to six PVOs to train health care providers and support them when they return to their clinics. A seventh grant is provided to CMC, a coordinating body for PVOs operating in the health sector. Each year, the PVOs submit requests to A.I.D./Rep for funds to continue their ongoing programs. The A.I.D./Rep health staff reviews these proposals in light of the previous years performance, changing conditions in Afghanistan, and A.I.D.'s health sector priorities.

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The key requirements of the PVO health program at this time are:

- An increase in the quality instead of the quantity of health care;
- Standardization of the PVO health programs to make them more sustainable in the Afghanistan context;
- Improvement of coordination between the PVO programs and the A.I.D. sector programs implemented by MSH; and
- A system to monitor and verify the quality and impact of health care inside Afghanistan.

These are all complex issues that require direct communication between the PVOs and the A.I.D./Rep health staff. This argues for the continuation of the existing management system. The U.S. PVOs receive direct grants which are reviewed, approved, and administered by the A.I.D./Rep health staff. In order to meet U.S. legal requirements, the non-U.S. PVOs are funded through a cooperative agreement with ICR, but these grants are also managed directly by the A.I.D./Rep health staff. This creates an administrative burden on the health staff, but is the only way in which the requirements listed above can be dealt with effectively. There is no question that a cooperative agreement similar to what was set up for RAP would adversely affect the ability of the health staff to manage the PVO health program.

It should also be noted that the option of making the PVO health activities a component of the MSH project is not a realistic one. The two programs need to be closely coordinated, and shifting the administrative burden of the PVO health program to MSH has a certain appeal, but the overriding factor is that PVOs do not see themselves as part of the MSH program and MSH is not interested in administering a set of PVO activities that are designed by the PVOs based on their own objectives and priorities. The result would certainly be reduced effectiveness in A.I.D./Rep's management of the PVO health program.

The PVO Rural Rehabilitation and Agricultural Input Distribution Program

Purpose: To increase agricultural productivity and rural incomes.

Outputs:

1. Rehabilitated irrigation systems;
2. Rehabilitated roads;
3. The distribution of agricultural inputs and equipment; and
4. Nonagricultural income-generating activities.

Recommended Management System:

The main management concerns with respect to these activities are their feasibility and their impact on agricultural productivity and rural incomes. In contrast to the health PVO grants, each rural rehabilitation grant is a distinct activity with its own feasibility and impact issues. Based on experience to date, A.I.D./Rep can expect 15 to 20 rural rehabilitation grant requests per year. This means that the review process for these grants is more time consuming than for health grants. However, most activities are small scale, localized, and do not raise major development policy issues.

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They therefore require less input from A.I.D./Rep Islamabad staff in the review and approval process. These factors argue for a cooperative agreement rather than direct grants for funding and day-to-day administration.

At present, most of the management responsibilities for the PVO rural rehabilitation program are shared by the IRC/RAP management unit and RAO/Peshawar. The role of IRC/RAP is to: (1) review grant proposals from PVOs prior to submitting them to RAO/Peshawar for approval, (2) monitor the implementation of the grants; and (3) receive quarterly implementation and financial reports from PVOs and pass them on to RAO/Peshawar. If IRC/RAP does its work properly, RAO/Peshawar (or A.I.D./Rep Islamabad for grants over \$500,000) can routinely approve the grant requests.

As noted in Part I, this management system has not functioned well in practice. The main reason is that IRC/RAP does not have the technical capacity to deal with the feasibility and impact issues related to each grant. As a result, IRC/RAP must continually consult with RAO/Peshawar during the approval process and act as an inadequately informed intermediary between A.I.D. and the PVOs. Alternatively, the PVOs bypass IRC/RAP and deal directly with RAO/Peshawar on issues likely to affect the approval of their grant. The end result is that, although the RAP cooperative agreement achieved its intended objective, reducing the administrative burden on the A.I.D./Rep staff, it did so at the expense of effective management.

There are two possible solutions. The first is to terminate the cooperative agreement and replace it with a system of direct grants which would be managed directly by RAO/Peshawar. This solution has one considerable advantage: A.I.D./Rep staff would be dealing directly with the implementing PVOs on an ongoing basis. As a result, the PVOs would have a better understanding of A.I.D./Rep concerns and A.I.D./Rep staff would have a better understanding of implementation problems and other issues facing PVOs. A second advantage is that the expertise available on the A.I.D./Rep staff would be routinely utilized in dealing with the feasibility and impact issues of individual grants. The main disadvantage is that the A.I.D./Rep office would have to hire additional staff, some expatriate and some local, which would considerably increase the cost of managing the program. It should be noted that a particularly onerous management task will be the in-country monitoring of the individual grants.

The second solution is to provide IRC/RAP with the capacity to assess the feasibility of grant proposals, and the likely impact, and carry out effective substantive monitoring of PVO activities as they are being implemented. This would involve adding an agriculturalist and an engineer to IRC/RAP. The main advantage of this solution is that the administrative burden of processing proposals and monitoring implementation would remain with an intermediary institution. At the same time, there would be improved communication between the PVOs and the A.I.D./Rep Office because IRC/RAP would now be able to present the PVO position effectively to A.I.D./Rep and communicate A.I.D./Rep concerns effectively to PVOs.

The main disadvantage is that, even if IRC/RAP is strengthened, it will not be given full management responsibility by A.I.D./Rep. Consequently, IRC/RAP decisions will always be subject to change and PVOs will find they still cannot communicate easily with the final decision makers. This inevitably results in duplication of effort and implementation delays and is perhaps the major reason why the first solution is the best from a management standpoint.

It should be noted that a third solution, keeping all substantive management responsibility in A.I.D./Rep and assigning all day-to-day administration to an intermediary institution is not recommended for either RAP or the PVO health program. Day-to-day administration is hampered by the inability to make substantive decisions, and substantive management is less effective when separated from day-to-day administration.

PVO Agricultural Development Activities

Purpose: To increase agricultural production, food availability, and rural incomes.

Outputs:

1. Introduction of new technologies;
2. Distribution of agricultural inputs and equipment;
3. Development of marketing channels and processing facilities; and
4. Development or rehabilitation of rural infrastructure.

Some of these outputs are similar to outputs under rural rehabilitation, but are on a larger scale and are usually implemented over several years.

Recommended Management System:

The first step that should be taken is to differentiate clearly between the simple rehabilitation and input distribution activities discussed above and more complex agricultural development projects which most PVOs are unqualified to implement. The two types of activities raise different issues and have different management requirements. As noted in Part I, the evaluation team recommends that most PVOs be discouraged from undertaking complex multi-year agricultural development projects. Nevertheless, at least two PVOs, SCF and MCI, are qualified to implement this type of project. A.I.D./Rep can expect that three or four fundable agricultural development projects per year could be proposed by PVOs.

These activities raise two types of issues for A.I.D./Rep management: feasibility and consistency with A.I.D. policies. How they are managed depends on how the A.I.D./Rep office sees the PVOs' role in its overall agricultural development program. If it sees PVOs as an important element in the program, their activities should be directly planned and managed by the A.I.D./Rep ADO staff in the context of A.I.D.'s overall sector program. If the PVO activities are seen as peripheral to A.I.D.'s sector program, A.I.D./Rep management need only review the proposals to assure that they are feasible and consistent with A.I.D. policies.

The second approach removes the need for direct grants. Since there are not likely to be many proposals for this type of activity and since most proposals will come from PVOs that are already receiving grants for rural rehabilitation, the management of grants to PVOs for agricultural development could be integrated into the rural rehabilitation program. As discussed in Part I, agricultural development proposals could be jointly reviewed by ADO and the management unit for the rural rehabilitation program (whether IRC/RAP or KAO/Peshawar), and managed by the latter during implementation. This relatively passive management approach recognizes that, as a general rule, PVOs are not well suited for implementing agricultural development projects, and grants to them for this purpose are exceptions rather than integral elements of the A.I.D./Rep agriculture sector program.

Other PVO Programs

The only other activities in the A.I.D./Rep PVO program are emergency grants, survival grants, resettlement grants, and grants to promote democracy and pluralism. The first two categories can be handled on a case-by-case basis as is currently being done by RAP. From a management standpoint, no major changes are needed. The last

two categories have not yet started. If and when they reach a significant level of activity, they should be designed as subprojects similar to what is recommended above for the PVO health and rural rehabilitation programs. Resettlement grants are likely to resemble rural rehabilitation grants and raise similar issues of feasibility and impact, which means that both cooperative agreements and direct grants would be appropriate funding mechanisms. Activities to promote pluralism and democracy, on the other hand, are more likely to be policy-oriented and should probably be funded and managed through direct grants to the implementing PVOs.

CONCLUSIONS AND RECOMMENDATIONS

The main findings and recommendations of the evaluation team regarding the overall management of the A.I.D./Rep PVO program are:

- There is no need for two PVO projects, although keeping them separate does not create any significant management problems. Whether or not they are combined into one project, there should be specific subprojects for health, rural rehabilitation, and agricultural development, each with its own objective (purpose) and management system.
- The management system for the PVO health program should be the model for PVO programs that raise important policy issues or are closely linked to the A.I.D./Rep sector programs. The main advantage of this system is direct contact between the A.I.D./Rep staff and the implementing PVOs. It is appropriate that the only function of the cooperative agreement is to meet U.S. government legal requirements with respect to nonregistered PVOs.
- The RAP cooperative agreement with ICR should be either terminated and replaced with a system of direct grants, or revised to give substantive management authority and capability to the intermediary institution. If it is terminated, a management unit will have to be created, preferably in RAO/Peshawar, and a new cooperative agreement similar to the one under the Co-Financing Project will be needed to channel funds to non-U.S. PVOs.
- Emergency grants, survival grants, rural rehabilitation grants, and resettlement grants can all be managed by one management unit. This unit can be IRC/RAP if the cooperative agreement is revised or RAO/Peshawar if the agreement is terminated.
- PVO agricultural development activities should be managed by the ADO through direct grants, but if they remain exceptions, as is recommended in this evaluation, they can continue to be managed as part of the PVO rural rehabilitation program, with ADO participation during the approval process. If they are to be funded through direct grants they should be shifted to the Co-Financing Project.

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ANNEX A
PROFILES OF RAP GRANTEES

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PROFILES OF RAP GRANTEES

AFGHANAID

Afghanaid is a British PVO that was established in 1983 in response to the need for emergency assistance to Afghans as a result of the Soviet invasion of Afghanistan. Initial grants were received from ODA, private sources, and, in 1985, from A.I.D. Initially, Afghanaid used its funding as cash-for-food (CFF) grants to Kunar and Panjshir provinces. Problems of accountability and administrative capacity in the administration of the initial \$2 million received in A.I.D. grants were reported in the Bakley report (Bakely, 1987). According to subsequent A.I.D. analyses, these problems were corrected by the hiring of additional financial specialists, the selection and training of monitoring staff, and the introduction of a revised accounting system.

Afghanaid has had a long association with Commander Ahmed Shah Massoud in the Panjshir Valley. The Afghanaid staff believe that Massoud has set up an excellent and fair relief distribution system through the creation of Reconstruction Committee within the Shura-i-Nazar, and has realistic plans both for the short term rehabilitation of the Panjshir region and for the ultimate development of the area. Afghanaid proposals have decided to capitalize on the effectiveness of this committee by concentrate staff and resources in the northeast. As a result, Afghanaid has withdrawn from some of its projects in other parts of the country, and, in some cases, has turned over its project activities to other PVOs (e.g., SCF/US in Zabul).

Afghanaid received an \$800,000 grant from RAP for village assistance activities the Panjshir in the fall of 1989. The grant was for cash for work (repair of irrigation systems), cash-for-food grants and for the purchase of seeds, fertilizer, and oxen. An excerpt from the final report for this grant reads: "Increasingly, Afghanaid is able to rely on the personnel of the Reconstruction Committee to implement projects." Among the accomplishments reported by Afghanaid for the Panjshir grant are: 6,074 returnee families provided with food and cash-for-food, PakRs one million worth of seed and fertilizer distributed, and two major bridges repaired. Planned irrigation rehabilitation work was delayed due to poor weather. Problems have been reported in the reallocation of funds for other purposes without the approval of IRC/A.I.D.; these may be minor, but do need to be corrected.

RAP also contributed approximately \$50,000 to the Salang emergency mission carried out by Afghanaid to assist bombing victims with the provision of food and cash-for-food.

In addition to its four recently-expired grants with RAP, Afghanaid has an additional four active grants which will expire in April, 1990. These are:

1. Subgrant no. 19: \$290,901 for Kunduz and Takhar Provinces: cash-for-work for irrigation repair, fertilizer and seed distribution, provision of hand tools, and canal repair.
2. Subgrant no. 20: \$304,061 for Badakhshan Province: irrigation repair, provision of fertilizer and seeds, and provision of tractors and a thresher for two districts (Baharak and Shahr-e-Bozurg).
3. Subgrant no. 21: \$334,200 for the Panjshir Valley: provision of oxen for animal traction, provision of seed and fertilizer, cash for food, and repair of irrigation canals.

4. Subgrant no. 22: \$144,338 for Khanabad and Kunduz: village assistance grants for 15 villages in Khanabad district, cash-for-work program to repair irrigation system, agricultural machinery including tractors and threshers, provision of seeds and fertilizer.

Activities supported by these four village assistance grants, totalling \$1,073,500, are in various stages of implementation. Irrigation repair has halted due to winter conditions, but, according to a recent monitoring report, materials have been purchased and stored, and oxen, treated wheat seed (obtained from FAO) and fertilizer was distributed in time for the winter wheat planting season.

Afghanaid advised the evaluation team that they would like to continue with short-term, agricultural and infrastructure rehabilitation projects. They wish to avoid complex construction projects which require more expertise than their 38 Afghan field workers possess. Their field staff of agriculturalists (technical school graduates) and engineers are supplemented by one Afghan agronomist who graduated from Kabul University and two short term expatriates who are students in an English agricultural college.

In the past Afghanaid has relied on expatriate volunteers to conduct monitoring trips inside Afghanistan. Although often professionals in their own fields, their lack of knowledge about Afghanistan was found to be a serious shortcoming. In July and August of this year Afghanaid, sent in a team of Afghan specialists who were familiar with the projects with more informative results. In the future, Afghanaid intends to send project officers with Afghan staff.

Afghanaid has a \$6 million operating budget, about one-third of which is derived from the eight projects described above.

AMITIE FRANCO-AFGHAN (AFRANE)

AFRANE is a Paris-based nonprofit humanitarian organization that has been active in Afghanistan since 1980. From its inception, AFRANE supported expatriate volunteers who delivered emergency relief assistance to the northern areas of Afghanistan. From 1985, a number of AFRANE's activities were supported by the US Government with \$571,000 of OFDA funds provided by the Office of the A.I.D./Rep with IRC acting as the intermediary grantor.

Since 1985, the AFRANE has begun to concentrate more on rehabilitation and agricultural development activities in various regions throughout the country. A.I.D. support accounts for more than fifty percent of AFRANE's funding, the balance of which is derived from the United Nations, the EEC, the French government and private donations. Since July 1988, AFRANE has received a total of \$1 million in RAP funding through six subgrants for activities in the provinces of Badakhshan, Herat, Kandahar and Logar.

AFRANE's initial two subgrants under RAP combined emergency, survival and village assistance grants. Building on its previous relationships with mujahideen commanders in Badakhshan and Herat, AFRANE staff identified target populations in Afghanistan that were in need of assistance, and empowered expatriate volunteers to deliver cash grants to representatives of those populations. Emergency funds were handed over to commanders who then arranged the purchase and distribution of foodstuffs among the target population. Survival and village assistance funds were channeled through local shuras for use in cash-for-work activities (especially the rehabilitation of irrigation works) and the distribution of food among the neediest of the target population.

AFRANE's four subsequent RAP subgrants have financed village assistance projects in Badakhshan, Herat, Kandahar and Logar. According to AFRANE's Peshawar-based representatives, these funds are distributed by AFRANE field staff through local shuras to finance the repair of irrigation works (e.g., the cleaning of karez and the rehabilitation of surface channels) as cash-for-work schemes. In addition, RAP funds have been used to establish wheat seed multiplication plots, to provide tractors, threshers and other mechanized equipment and set-up of mechanic workshops. Project field staff charged with implementing each subgrant include Afghan agriculturalists and civil engineers who work under the periodic supervision of an expatriate agronomist and Afghan project manager based in Peshawar. AFRANE supports one expatriate supervisor for its projects in Kandahar province.

AFRANE employs four french nationals and 26 Afghan professional staff in addition to its Afghan support staff. All senior Afghan field staff are reported to be qualified agriculturalists or engineers. AFRANE's Paris office exercises little substantive control over the activities of the Peshawar field office but serves mainly as a fund-raising and public information organ. The Paris office also coordinates the activities of technical specialists who volunteer their services to AFRANE's activities.

AFRANE's Peshawar-based expatriate staff are responsible for developing project proposals, which they do in coordination with the relevant committees of both ACBAR and SWABAC. Although AFRANE coordinates its activities with the Ministry of Reconstruction of the Afghan Interim Government in Peshawar, the Peshawar-based representatives reported that the organizations substantive relations remain with the commanders and local shuras who hold authority in its target areas.

AFRANE's Peshawar-based staff is solely responsible for monitoring projects. Reportedly, one expatriate staff member of AFRANE visits each project site at least once each year, and the Peshawar-based agriculturalist meets the expatriate Kandahar project supervisor each month in Quetta. Within the past year, AFRANE has attempted to upgrade its monitoring capacity through more detailed analysis of project impact on areas of cultivation, crop yields and numbers of beneficiaries in target areas. This includes the use and analysis of satellite photography of target areas.

According to AFRANE staff, RAP funding has enabled the organization to expand the scope of its activities in Afghanistan from providing emergency assistance to more enduring relief and rehabilitation assistance. However, the one-year funding limit on all RAP projects, and the lack of clear-cut guidelines restricting developmental activities, have constrained AFRANE from pursuing its longer term assistance goals for Afghanistan.

In April 1988, RAP contracted with an expatriate member of a CMC monitoring mission to southern Afghanistan to report on Solidarité and AFRANE assistance activities in Kandahar. The monitor's report provided anecdotal information on both PVOs' activities such as cash-for-food distribution, the purchase of agricultural inputs (e.g., seed and water pumps), the cleaning of karezes and the construction of flood protection works. However, the monitor did not indicate any clear relationship between the activities observed by the monitor and AFRANE's assistance objectives. The monitor's recommendations indicated that there was a lack of sufficient technical expertise on AFRANE's construction sites.

AFRANE's most recent proposals for karez and irrigation channel cleaning in Badakhshan, Logar and Herat were reviewed by the A.I.D., Rep Engineering Advisor in September. The advisor identified deficiencies in each proposal relating both to technical design and material cost estimates. The advisor approved each proposal on the condition that AFRANE submit quarterly monitoring reports that include "detailed design and cost estimate justification and calculations for the approval of IRC and A.I.D./Rep." The advisor indicated that guidelines would be developed for reviewing RAP funded projects

and that "failure to meet the requirements of the guidelines could result in suspension of project funding." Unfortunately, the position of Engineering Advisor will fall vacant before AFRANE can feasibly submit monitoring reports on any of its proposed projects. As a result, RAP staff will remain unable to evaluate the technical feasibility and cost effectiveness of these projects. A.I.D./Rep will have to make alternative arrangements to review the technical information to be provided by AFRANE.

CARE

CARE has received a \$1.044 million grant under RAP for a PL-480 Food for Work project in Kunar Province. RAP in this case was used as a convenient funding-vehicle for a project that does not fit neatly within RAP objectives. The CARE project is considered by A.I.D./Rep and CARE as a pilot activity to test ways of using PL-480 food to support the repatriation of Afghan refugees. More specifically, the food provided under the CARE project will 1) pay for rehabilitation work that will be needed by returning refugees, and 2) assure that sufficient food supplies will be available until local food production can meet the needs of the population. Kunar Province was selected because two thirds of its original population are refugees, and it will be one of the first major destinations once refugees start returning.

The approval process for this grant was extremely lengthy. CARE, at A.I.D.'s request, prepared a proposal in December 1988 and submitted it to A.I.D. in January. During the next two months discussions were held between CARE, A.I.D./Rep, and the AIG (Ministry of Reconstruction) to refine the proposal and decide where it was to be implemented. It was clear during this process that the AIG would have the final say on where the project would be located. The AIG finally approved the project in May, but implementation was delayed because CARE was unable to obtain a No Objection Certificate (NOC) from the Government of Pakistan. The NOC was finally obtained in July.

In the meantime CARE and A.I.D. were negotiating the details of the project budget. The major change during this period concerned the transportation of the food from Peshawar to the final destination. This was originally to have been funded by A.I.D. through the Afghan Construction and Logistics Unit (ACLU), but in June the decision was made to shift the funding to RAP. The effect was to increase the budget from about \$490,000 to \$1.045 million.

There is general agreement in A.I.D./Rep and IRC/RAP that RAP was not intended to fund \$1 million "pilot" projects to test ways of using PL 480 in Afghanistan. RAP was designed to fund small quick impact relief and rehabilitation activities. The typical grant is less than \$500,000. Grants over that amount are considered relatively large, certainly not pilot activities, and must be approved in Islamabad. The evaluation team was told by A.I.D./Rep that future support of CARE food-for-work activities will probably be through direct grants.

Since this activity is just getting started, it is too early to assess implementation. However, it can be noted that CARE has had extensive world-wide experience in designing and implementing food for work projects, and two senior CARE staff have been assigned to this project. At this time, the major identifiable problem is in-country monitoring. Since CARE has been unable to recruit a non-U.S. expatriate for this function, it may have to rely on Afghan monitors. Based on the experience of other PVOs, it will be very difficult for CARE to build up an Afghan monitoring capacity within the time frame of this subgrant. Since this project is justified primarily as a pilot activity, effective monitoring would seem critical to the achievement of its objectives.

COORDINATION FOR HUMANITARIAN ASSISTANCE

The Coordination for Humanitarian Assistance (CHA) is an Afghan PVO formed during the summer of 1989. In November 1989, CHA was provided a RAP subgrant of \$263,000 to provide village assistance to target populations in five districts of the western province of Farah.

The Chief Coordinator of CHA and two support staff are based in Quetta. The Chief Coordinator will support the activities of an agricultural engineer and an assistant in each of the three project areas, plus a civil engineer who will visit each of the project areas as work progresses. The primary objectives of the project are to clean and repair existing irrigation works to restore the pre-1979 agricultural capacity of the project areas. Project staff will work closely with local shuras to determine priority project activities.

The funding of CHA represents a test case for RAP's ability to identify, develop and support Afghan organizations as potential implementing agencies for relief and rehabilitation assistance. In June 1989, The RAP expatriate monitor visited the project areas with CHA's Chief Coordinator and collected data that served as a basis for planning the proposed projects. RAP administrative staff subsequently worked with the Chief Coordinator to draw up a proposal suitable for RAP funding. Once implementation begins, RAP administrative staff will continue to work with the Chief Coordinator to prepare quarterly narrative and financial reports.

RAP administrators admit that their support for CHA has consumed a disproportionate amount of their time and energy compared to the support that they provide to other PVOs. However, considering the fact that Farah, because of its remote location, has received little relief assistance during the past decade, the promotion of an indigenous capacity to implement assistance projects appears to merit the effort.

MERCY CORPS INTERNATIONAL (MCI)

Mercy Corps International received its first rural assistance grant from RAP in September 1988. MCI has strong ties to mujahideen commanders in southern Afghanistan, particularly the Kandahar area, because of their earlier established medical programs.

In August 1988, MCI applied to RAP for an Emergency Assistance grant of \$49,990 to assist villages surrounding Kandahar city. The population of 20 villages in the Arghandab district north of Kandahar city and the east bank of the Arghandab River were forced to leave their homes because of aerial bombardment in June 1988. RAP funds were received in November and a total of 1,871 families were given cash-for-food grants of Afs 1000 each. Funds were distributed through the Kandahar shura, despite some resistance from a local commander, and the MCI mission was completed by Christmas.

MCI's second RAP grant, a village assistance grant of \$200,000, was approved in September 1988. This grant, also for assistance activities in the southwest, targeted the districts of Shinkai, Maruf and Arghistan. MCI's activities included karez repair, the provision of agricultural inputs such as seed, fertilizer and agricultural equipment, including a thresher. In the course of implementing this grant, MCI accumulated good, practical field experience in the repair of karezes. As a result, MCI has been able to arrive at accurate estimates for the cost of karez repair under various types of soil conditions.

MCI has proposed two other projects to IRC/RAP which were not funded. One, a cash crop substitution project, was rejected because of the project's proximity to the poppy growing areas of Helmand. The second, a proposal to repair 20 grape drying sheds (*kishmish khana*) in Kandahar, was rejected because RAP management felt the sheds were privately owned and the project funds would only benefit a small number of individuals.

In the course of submitting both of these proposals, MCI received conflicting, and in some cases, contrary advice from A.I.D./Rep Islamabad and the RAO in Peshawar. As no fault has been found in the implementation of subgrants No. 4 and No. 5 above, the evaluation team felt that the mixed communications between RAO/P and IRC/RAP prevented MCI from obtaining funding for its projects.

MCI has three Canadian agriculturalists on its staff. One is new to the organization and one will depart this spring, although MCI has plans to replace him. In addition, MCI has trained Afghan rural development specialists who oversee implementation of projects in the field.

MCI agriculturalists have been active in the SWABAC coordination meetings and often seek advice and exchange ideas with the UNDP/FAO Quetta-based agriculturalist. They have received UN funding to continue their agricultural rehabilitation work in southern Afghanistan. With those funds, they have initiated a livestock vaccination program for cattle (Black Quarter) and small stock (anthrax and enterotoxemia); they have also done de-worming of small stock.

The main problems that MCI has encountered with the RAP program have been MCI's limited communications with Peshawar. MCI's attempts to deal directly with A.I.D./Rep have led to confusion and contradictory advice.

MCI became involved in the sale of US fertilizer for A.I.D./Rep in November. Sales went smoothly despite the fact that other PVOs in the region had been providing fertilizer free of charge to their beneficiaries.

MERCY FUND

Mercy Fund, a U.S. PVO, has received three grants under the RAP: two emergency grants in Nangarhar near Jalalabad, for \$116,250 and \$111,468, and a village assistance grant for the Ghaziabad farms for \$290,900. Mercy Fund has been in Peshawar since 1986 implementing mostly health and mine awareness programs in the refugee camps as well as inside Afghanistan. The Mercy Fund office in Peshawar consists of a country director and a projects coordinator, both Americans, a refugee programs office, a cross border programs office, and a controller, all staffed with Afghan professional and support personnel.

RAP funding for Mercy Fund started in April 1989 in connection with the siege of Jalalabad. Through its contacts, Mercy Fund received a request for relief help for people being displaced because of the conflict. The request sent to IRC/RAP in mid-March and was approved and funded on May 25, over two months after the original request. There was still a need for relief assistance, but the two month delay is clearly not appropriate for emergency assistance.

Mercy Fund requested a second emergency grant for the same area in early August 1989. This was quickly approved by IRC but was delayed slightly in A.I.D. because the combined administrative and operating expenses were higher than standards that had been set by A.I.D. but not communicated to IRC. The subgrant agreement was signed on August 21 for implementation between September 15 and November 30, 1989.

Contacts established through these two emergency grants led to a request from authorities in the Ghaziabad area for assistance to rehabilitate two of the Ghaziabad state farms for olive production. These farms had been allowed to deteriorate so that olive tree yields were only 20 percent of pre-war levels. Mercy Fund had conducted field surveys of the area and obtained advice from production and marketing experts in the Peshawar area, including Dr. Wakil of VITA. They also consulted with Save the Children which was implementing a project on a neighboring state farm. The proposal made clear that the full return of these farms to pre-war production levels would take several years. This first grant was to save the trees from further deterioration and consisted largely of cash for work. As many as 1,000 workers were to be employed over a four to five month period.

The project was quickly approved by IRC but raised two issues for A.I.D.. First, the goals of this project were clearly long-term and beyond the scope of the project as perceived by the A.I.D. project manager. Second, the assistance was to a state farm which was now nonoperational but which would one day probably return to government ownership and management. Because the grant was for less than \$500,000, these issues were not officially addressed in Islamabad and the activity was quickly approved on the grounds that it met RAP's short-term employment objectives. Mercy Fund has recently submitted a proposal for a second phase activity in Ghaziabad which raises the same issues as the previous grant. This proposal has been reviewed in depth by IRC and will probably have to be reviewed by the Agriculture Office in Islamabad before a final decision is reached.

Grant reports have not enabled the evaluation team to verify that the activities were implemented as planned. It appears that the emergency grants were satisfactorily monitored. The implementors report frequently to the Peshawar office and these reports often include pictures to document what is happening. The Ghaziabad project, on the other hand, does not have a monitoring and evaluation plan that corresponds to the complexity of the undertaking. This is reflected in the relatively uninformative quarterly reports. On projects of this type, Mercy Fund should identify critical implementation and design issues at the proposal stage and should require regular reports from the field on these issues. The information in these reports should be passed on to IRC and A.I.D.

Based on experience to date and discussions with the Mercy Fund Director and Projects Coordinator, it appears that Mercy Fund is becoming increasingly interested in agricultural development projects. For example, they are presently working on a proposal for a poultry production project. Their approach seems to be that, as income generating activities are identified and appear feasible, Mercy Fund will recruit staff and build up the expertise necessary to implement the activities. This means that future Mercy Fund proposals will, if approved by A.I.D., contribute to a shift in RAP funding from short-term rehabilitation activities to medium-term agriculture projects. This will require an increased role for the Agriculture Office in the review and management of RAP subgrants.

SAVE THE CHILDREN FEDERATION (SCF/US) 11

Save the Children Federation is an American organization created to assist children through community development programs throughout the world. In Pakistan, SCF has offices in Quetta and Peshawar, Mianwali and Manshera, and a headquarters in Islamabad. A newcomer to the Afghan cross-border arena, SCF began its activities with a village assistance grant for work in Zabul province in 1988.

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The initial grant provided funding for karez repair, seed distribution, and survey work in Zabul. The number of karezes actually repaired exceeded the number planned for in the proposal, but no seeds were distributed because SCF felt that trial plots needed to be established. Surveys completed in the initial grant formed the basis of subsequent applications for funding.

Two active grants, totalling nearly \$700,000 for Zabul province, are managed by the Quetta office. The grants provide agricultural inputs (hand tools, seeds, and fertilizer), a karez repair program, and funds for the repair of village roads and bridges. Both grants expire in January, 1990.

The Peshawar office of SCF manages two grants under the RAP project that total approximately \$800,000. Both provide assistance to the Nangahar, Ghazni regions. The smaller grant (\$137,000), is an income generating project for women which sends handicraft kits to women in Afghanistan and assists in marketing of the final product. This women's program is an extension of similar, and highly successful, SCF efforts in the refugee camps. SCF staff estimate that the project in Afghanistan an income of about Afs 1000 per month per beneficiary. The second grant is a rural development activity which is based in Ghaziabad farm, a former Soviet-run research and production farm. SCF staff are repairing irrigation systems, providing fertilizer, and providing improved seeds in the area. Both grants expire in January 1990.

SCF follows a method of project selection which includes an analysis of area needs, followed by research in Peshawar or Quetta, consultation with experts from the UN, VITA, and others, and a survey of the project site. All proposals are forwarded to Islamabad headquarters prior to submission to RAP for approval, but the regional office managers have autonomy in the day-to-day decisions of project management. All SCF projects require a 25 percent contribution in cash or kind from their beneficiaries before field agreements are signed. SCF feels that these contributions are essential to insure success of the projects. SCF staff believe that their projects have enabled some 700 people in the Ghaziabad farm area to remain in their homes rather than seeking food and work across the border.

SCF's RAP grants have totalled \$1.5 million. In 1989, these funds accounted for about 50 percent of its Afghanistan program budget. The remainder is made up of UN grants and private contributions. SCF management describes their relationship with IRC/RAP and A.I.D./Rep as good, although they would prefer a direct relationship with A.I.D./Rep and find IRC/RAP deficient on technical matters. Both offices participate in SWABAC and ACBAR and are active in regional and sectoral subcommittees.

SCF/P has employed 12 agriculturalists, most of whom were trained at Kabul University. The senior agronomist was trained in the US and later managed the A.I.D. Helmand Valley project. The Ghaziabad site manager is a former Ghaziabad farm manager. SCF has its own monitoring teams, and some of projects have been monitored by UN and IRC/RAP staff. A recent IRC/RAP monitoring report staff was found to be technically incorrect on many details of SCF's Ghaziabad project activities. The report will be resubmitted to IRC/RAP for corrections.

SCF is interested in supporting development rather than simple relief and rehabilitation projects and is hiring technical staff accordingly. It has recently hired an agricultural economist for its Quetta office and its survey activities are oriented towards identifying community level development projects. It can be expected that some if not most of SCF's future proposals will be for agricultural projects, which will require Agriculture Development Office review.

SOLIDARITÉ AFGHANISTAN

Solidarité Afghanistan (formerly *Guilde du Raid*) is a Paris-based humanitarian organization that has been active in Afghanistan since 1980. Between 1980 to 1987, expatriate volunteers serving with *Guilde du Raid* undertook numerous missions to provide cash-for-food grants to target populations in at least ten provinces of Afghanistan. From 1985, a number of these missions were supported by the US Government with \$1,558,000 of OFDA funds provided by the Office of the A.I.D./Rep with IRC acting as the intermediary grantor.

Building on their previous experience in the country, *Guilde* volunteers formed Solidarité in 1987 to focus donor attention exclusively on Afghanistan. A.I.D. support, in the form of RAP subgrants, accounts for at least fifty percent of Solidarité's funding, the balance of which is derived from the United Nations, the EEC, the French government and private donations, including grants from Peshawar-based PVOs. In June 1988, RAP awarded Solidarité a subgrant of \$800,000 to provide village assistance and survival support to target populations in Herat, Kabul, Wardak, Kandahar provinces and selected areas of northeast Afghanistan.

Under its RAP subgrant, Solidarité financed five separate assistance missions to Afghanistan, each with a budget of \$166,000. Mission teams were made up of both expatriate and Afghan members who had undertaken earlier missions for Solidarité/*Guilde du Raid*. A number of teams included expatriates with technical expertise in agriculture and engineering. Missions lasted up to two months on average and were targeted for areas previously served by Solidarité/*Guilde du Raid* teams. This previous experience enabled Solidarité staff to determine specific assistance requirements for each target area. According to Solidarité Mission Reports, expatriate teams worked with the established *shuras* and local administrative structures in each target area to distribute cash-for-food grants to needy groups and to support rehabilitation projects identified by local leaders. For example, the Solidarité mission to Herat financed the purchase of agricultural tools, the construction of a brick kiln, the development of a pilot sericulture project and cash wages to laborers for the repair of roads.

Solidarité employs a staff of three Peshawar-based expatriates and a small number of Afghan "technicians" in its project catchment areas in Kandahar and Wardak. The Paris headquarters, with its staff of two persons, serves primarily as a fund raising and public awareness organ, in addition to coordinating the participation of volunteer technicians in assistance missions planned by the Peshawar field office. Peshawar-based staff participate in the regional and sectoral subcommittees of both ACBAR and SWABAC. The Peshawar-based administrator for Solidarité liaises with the leaders of the Afghan mujahideen political party leaders that are influential in the areas where Solidarité undertakes its missions. Coordination with the Ministry of Reconstruction of the AIG is, according to the Solidarité administrator, more problematic. Because that Ministry is seen to be dominated by one mujahideen political party, the administrator is reluctant to divulge to the Ministry's representatives details of Solidarité activities in the areas dominated by other parties. In the end, according to the Solidarité administrator, the organization's most significant counterparts are those commanders in Afghanistan with whom Solidarité mission members have developed and maintained working relations for nearly a decade.

While Solidarité appears to have considerable experience and capacity for operating in Afghanistan, its present style of project implementation and management would prevent the organization from undertaking more sophisticated relief and reconstruction activities. Solidarité staff appear to deliver much needed resources, but its implementation missions are of such short duration that they provide no continuous accountability for the use of those resources. Solidarité mission reports indicate how project resources are allocated in the field but mission members are unable to monitor the impact of the assistance

provided. Without regular monitoring of its own assistance activities, Solidarité can only verify the effectiveness of its assistance through follow-up missions.

In April 1988, RAP contracted with an expatriate member of a CMC monitoring mission to southern Afghanistan to report on Solidarité and AFRANE assistance activities in Kandahar. The monitor's report provided anecdotal information on both PVOs' activities such as cash-for-food distribution, the purchase of agricultural inputs (for example, seed and water pumps), the cleaning of karezes and the construction of flood protection works. However, the monitor did not indicate any clear relationship between the activities observed by the monitor and Solidarité's assistance objectives.

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ANNEX B
BREAKDOWN OF RAP SUBGRANTS

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**ANNEX B
BREAKDOWN OF RURAL ASSISTANCE PROJECT SUB-GRANTS**

Sub-grantee	Sub-grant No.	Category	Location	Survival:	Village	Emergency	Total	Start	End
AFRANE	1	Emergency	Herat, Badakhshan			\$49,985	\$49,985	7/88	12/89
AFRANE	2	Village Assit/Survival	Badakhshan	\$335,818	\$304,328		\$640,146	7/88	12/89
SCF/US	3	Village Assit	Zabul		\$33,050		\$33,050	7/88	11/88
MCI	4	Village Assit/Survival	Kandahar	\$22,502	\$177,498		\$200,000	9/88	5/89
MCI	5	Emergency	Southwest			\$49,990	\$49,990	9/88	1/89
Afghanaid	6	Village Assit/Survival	Penjshir	\$673,869	\$126,131		\$800,000	9/88	9/89
Solidarites	7	Village Assit/Survival	Her, Kan, Kab, War, HE	\$583,529	\$215,471		\$800,000	1/89	5/89
Afghanaid	8	Survival	Badakhshan	\$230,791			\$230,791	1/89	5/89
SCF/US	9	Emergency	Selang Hwy			\$49,990	\$49,990	1/89	5/89
SCF/US	10	Village Assit	Mangarhar, Ghazni		\$656,299		\$656,299	1/89	1/90
SCF/US	11	Village Assit	Mangarhar, Ghazni		\$137,016		\$137,016	1/89	1/90
SCF/US	12	Village Assit	Zabul		\$297,633		\$297,633	1/89	1/90
SCF/US	13	Village Assit	Zabul		\$373,438		\$373,438	1/89	1/90
Mercy Fund	14	Village Assit	Jalalabad			\$116,250	\$116,250	5/89	7/89
Afghanaid	15	Emergency	Mirroz, Helmand			\$43,060	\$43,060	6/89	10/89
AFRANE	16	Village Assit	Badakhshan		\$299,800		\$299,800	7/89	4/90
Mercy Fund	17	Emergency	Jalalabad			\$111,568	\$111,568	9/89	11/89
Mercy Fund	18	Village Assit	Ghazni		\$277,605		\$277,605	9/89	12/89
Afghanaid	19	Village Assit	Kunduz, Takhar		\$290,901		\$290,901	8/89	4/90
Afghanaid	20	Village Assit/Survival	Badakhshan	\$26,316	\$277,745		\$304,061	8/89	4/90
Afghanaid	21	Village Assit/Survival	Penjshir	\$60,000	\$274,200		\$334,200	8/89	4/90
Afghanaid	22	Village Assit	Kunduz		\$144,338		\$144,338	8/89	4/90
CARE	23	Village Assit	Kunar		\$1,044,911		\$1,044,911	8/89	4/90
AFRANE	24	Village Assit	Kandahar		\$166,998		\$166,998	9/89	4/90
AFRANE	25	Village Assit	Badakhshan		\$89,775		\$89,775	9/89	4/90
AFRANE	26	Village Assit	Ghazni		\$143,827		\$143,827	9/89	4/90
CIA	27	Village Assit	Farah				\$263,000	11/89	4/90
TOTALS for categories				\$1,932,825	\$5,331,964	\$420,843	\$7,948,442		

Source: RAO/Peshawar

FIGURE 1
RAP SUB-GRANTS BY PVO
(in millions \$US)

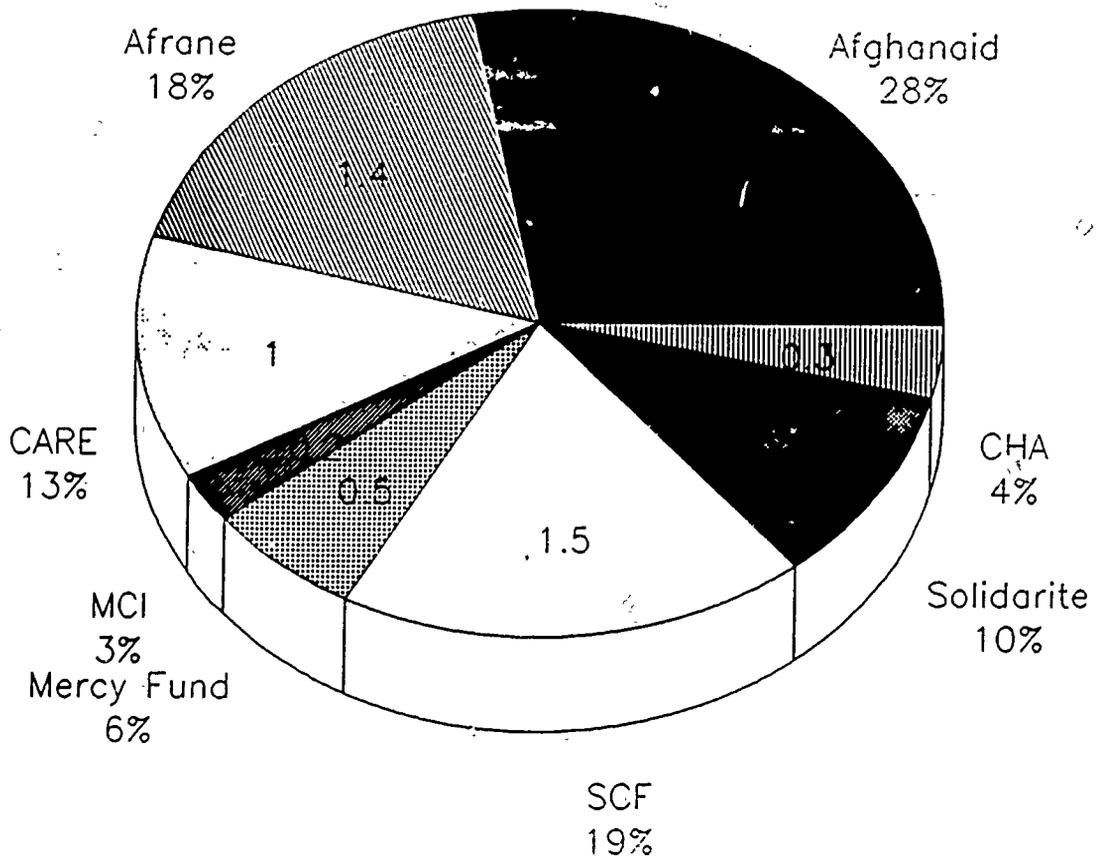
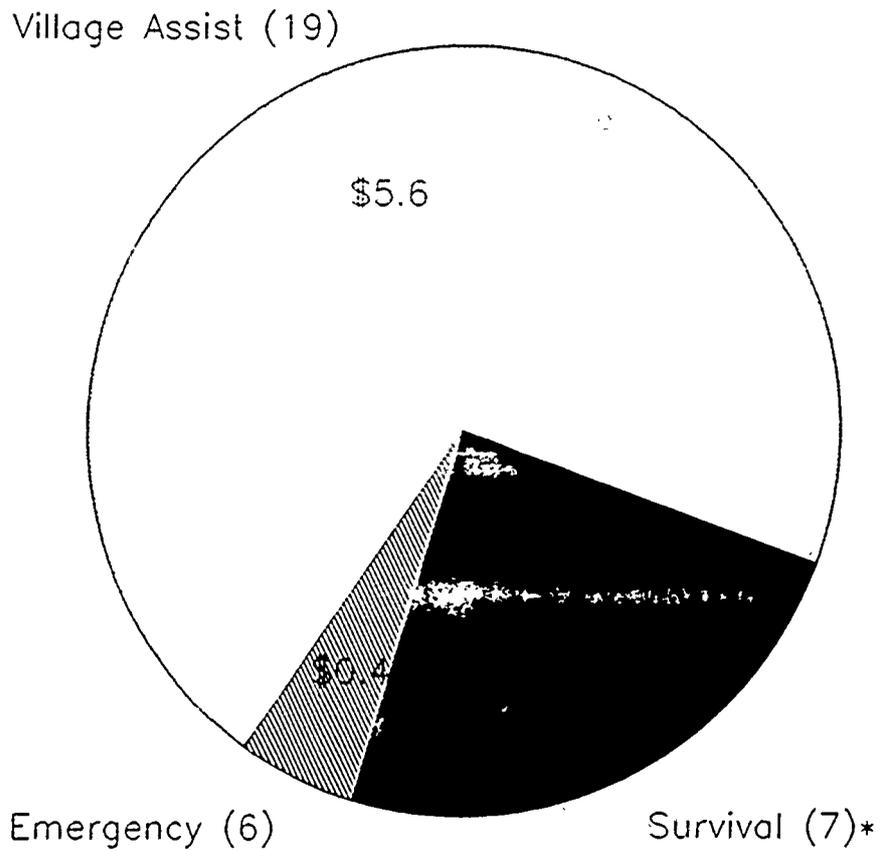


FIGURE 2
RAP SUB-GRANTS BY PVO
(in millions US\$)



* Number of sub-grants (includes double counting of grants that are more than one category)

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ANNEX C
SUGGESTED CRITERIA FOR RAP SUBGRANT APPROVAL

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ANNEX C

SUGGESTED CRITERIA FOR RAP SUBGRANT APPROVAL

The following criteria are recommended as guidelines for the types of assistance project proposals that may be submitted to IRC/RAP for funding. The parameters of the existing categories of RAP subgrants -- Emergency Assistance, Survival Grants, Village Assistance and Resettlement Grants -- have been clarified at the suggestion of a number of RAP subgrantees. Two additional categories of subgrant -- Repatriation Assistance and Developmental Assistance -- have been proposed to encompass both the potential expansion of RAP subgrantee activities in the area of Afghan refugee repatriation and long term agricultural projects.

- 1) **EMERGENCY ASSISTANCE** -- The rationale for funding this type of assistance was to provide immediate relief to Afghan populations that had suffered from the direct effects of military offensives. While that need has diminished considerably since the withdrawal of Soviet troops, the need for rapid response to natural calamities during the course of Afghanistan's rehabilitation remains great. To qualify for funding under this category of RAP subgrant, a PVO must:
 - Verify the existence of an emergency;
 - Verify that there is an effective local authority with whom the PVO can implement its assistance activities; and
 - Demonstrate that it has the capacity to implement the activities proposed.

- 2) **SURVIVAL GRANTS** -- The rationale for funding this type of assistance was to enable civilian victims of military offensives to remain in their villages and not join the ranks of the internally displaced or the refugees settled in Pakistan. Cash-for-Food grants and direct distribution of food and basic necessities are the major assistance components of this category of RAP subgrant. To qualify for funding under this category, a PVO must:
 - Verify the conditions that jeopardize the survival of the target population and verify the specific need for survival assistance;
 - Verify that there is an effective local authority with whom the PVO can implement its assistance activities; and
 - Demonstrate that it has the capacity to implement the activities proposed.

- 3) **VILLAGE ASSISTANCE** -- The principal objectives of Village Assistance activities in Afghanistan are to increase agricultural productivity, generate employment and increase rural incomes. Among the activities that would qualify for RAP funding under this category are:
 - Rehabilitation of irrigation systems;
 - Road repair;
 - Distribution of agricultural inputs and tools; and

- Provision of farm power resources (draught animals, tractors, tillers, threshers and pumps).

Activities that would not qualify for Village Assistance funding, or would require special justification for support include the rehabilitation of public buildings such as mosques, shrines, schools and clinics.

To qualify for Village Assistance funding, a PVO must:

- Verify the need for assistance activities in a given locality;
- Verify that there is an effective local authority with whom the PVO can implement its activities;
- Verify that proposed activities do not overlap with the activities of other PVOs or A.I.D./Rep agricultural sector support activities in the same area;
- Demonstrate the technical feasibility of proposed activities, e.g., prepare design and materials cost estimates; indicate the availability of local materials and commodities; indicate the availability of transport; indicate the availability of local labor;
- Demonstrate that proposed activities can be implemented at a reasonable cost;
- Require a local contribution of up to 25 percent of the cost of the project in cash or kind (materials and labor), or demonstrate why such a requirement would not be feasible; and
- Demonstrate a capacity to implement the proposed activities.

In addition, support for the rehabilitation of privately-held productive resources (e.g., *kishmesh khana*) can be considered to the extent that these activities will generate sustainable local employment and income, and that the owner of the resource makes a matching contribution of at least one half of the rehabilitation costs. Activities that target the rehabilitation of former state farms should not be considered unless the PVO has demonstrated the feasibility of the long-term viability of the undertaking, and that the project will lead to substantial long-term employment.

- 4) **RESETTLEMENT ASSISTANCE** -- The objectives of this category of RAP grant is to assist internally displaced and refugee populations who have returned to their villages of origin in re-establishing their agricultural or commercial livelihoods. Resettlement Assistance combines both Survival and Village Assistance activities and, to that extent, funding criteria for each should be applied to resettlement subgrant proposals. In addition, because PVOs may not have had working experience in the area targeted for resettlement assistance, the following criteria should be applied to proposals for this category of funds:

- PVOs should demonstrate the feasibility of resettlement for the target population by assessing the social and economic conditions of the areas to which that population proposes to return; and
- Resettlement Assistance activities should only be undertaken in the target area. No assistance should be provided to internally displaced or refugee populations to facilitate their physical relocation.

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ANNEX D
SCOPE OF WORK

ANNEX D

SCOPE OF WORK

BACKGROUND

A.I.D. has supported PVOs since the Afghanistan Cross-Border program began in 1985. Currently, the Mission has two PVO projects: PVC Co-Financing and Rural Assistance. It is expected that A.I.D. will provide \$14.0 million in both FY 1989 and 1990 to support ongoing and new PVO activities for Afghanistan.

The PVO Co-Financing Project was authorized in March 1986. It currently has an authorized funding level of \$35.0 million and a PACD of March 1991. Selection criteria under this project are intentionally broad and flexible. The project originally supported activities in health, cash-for-food, education and agriculture. It was focused mainly on health activities since the establishment of the Rural Assistance Project, but a planning grant to CARE, Inc., for a new food-for-work project was recently funded. The Mission is reviewing two proposals for new, unregistered refugees, and additional activities may be considered, especially when refugees begin to return to Afghanistan. Grants awarded through the PVO Co-Financing Project have been made directly by A.I.D. through intermediaries; specifically, the International Rescue Committee (IRC) and AmeriCare.

The Rural Assistance Project (RAP) was authorized in May, 1988, for \$10.0 million and has a PACD of September 1990. Its three components include: 1) grants to families for emergencies caused by military activities or natural disasters; 2) grants for village assistance with an emphasis on rural income and improved productivity; and 3) grants for vanguard resettlement activities. The RAP is administered by the IRC, which reviews proposals and recommends to A.I.D. approval or disapproval, monitors subgrantee activities financed under the project and assists the subgrantees in strengthening their administrative capabilities.

SCOPE OF WORK

Part I. Project Objectives

1. Review the past, present, and planned roles of PVOs in helping to implement certain elements of the CBHA program.
2. Examine the A.I.D.-financed activities of each PVO and determine the degree of success each has achieved in meeting stated objectives. Recommend ways in which each activity can be strengthened in critical areas.
3. Review and evaluate the monitoring, accountability, and internal evaluation systems of each PVO and assess the extent to which each has adopted creative operational systems beyond the basic input-output model.
4. Review and identify the causes for the recently growing level of objections by the Afghan Interim Government (AIG) and the Government of Pakistan (GOP) to PVO activities inside Afghanistan. Identify the short and long-term implications for a continuation of this trend of objections.

II. General Effectiveness

Subpart A: A.I.D. Performance

Review existing mechanisms used by the A.I.D./Rep to finance and manage PVOs and recommend changes/alternatives to improve them. These include direct grants and Cooperative Agreements with intermediaries to which varying amounts of authority are delegated.

Review the current mix of PVO activities to determine whether A.I.D. has set priorities and allocated funds in a manner proportionate to the needs inside Afghanistan and to the PVO community's ability to respond to those needs.

Determine the effectiveness of the A.I.D. project officers as catalysts for effective communications and coordination among PVOs and between PVOs and the major sectoral contractors, especially with regard to resource and information/data sharing.

Subpart B: PVO Performance

Review and evaluate the field coordination and collaboration among the various PVOs and determine the degree of effectiveness in avoiding unnecessary overlap and duplication of effort and in achieving standardized selection criteria and operational approaches.

Review and determine the effects of the relatively high rate of turnover among expatriate technical personnel on PVO project activities. Ascertain the level of success of the PVOs in recruiting expatriate technical staff for tours of duty exceeding six months.

Determine and evaluate the degrees and levels of active Afghan technical involvement in PVO activities. Determine if Afghans are sufficiently involved in data collection and analysis, monitoring, and evaluation. Determine if data collected in the field are analyzed locally.

Review and determine whether PVOs are complying with the monitoring and evaluation guidelines provided by the Mission (that is, are PVOs submitting timely and standardized periodic reports to the Mission? Do these reports present organized and logically presented data?).

Review and determine the extent of effective coordination and collaboration of activities between the PVOs and principal A.I.D. contractors in major health, education, and agriculture sector projects.

Determine the extent of coordination of activities by participating bodies on both sides of the border (that is, administrative operations in Pakistan and technical operations in Afghanistan). Identify road blocks to more effective coordination.

Review and assess the relationship between the headquarters and the field operations of each PVO. Ascertain if the field office has been given adequate authority. Identify the percentage of the budget allocated to headquarter operations and determine if this level is justifiable.

Identify the level of success PVOs have had in diversifying their funding sources decreasing their dependency on the U.S. government for financial support.

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9. To the extent possible, evaluate the impact of the activities implemented by participating PVOs.
10. Review and determine the degree of overlap with similar activities, using the same PVOs funded by other donors (United Nations, etc.).
11. Determine the extent to which the U.S. PVOs have been able to overcome the handicap caused by the prohibition of A.I.D.-funded Americans entering Afghanistan. Assess the capacity of the U.S. PVOs to absorb and effectively use increased levels of USG resources.

Part III: Health PVOs Specific

(The following items in the SOW are specific to the health activities of the PVO Co-Financing Project).

1. Evaluate the adequacy and effectiveness of the training programs, including the curriculum content and training technique and the location, number, level, and types of facilities used for training.
2. Review and determine the adequacy of PVO follow-up with former trainees and beneficiaries, to the extent possible, including, but not limited to, patients inside Afghanistan.
3. Evaluate the appropriateness, adequacy, and effectiveness of the types and levels of health services and commodities provided.
4. Ascertain if there is uniformity among health PVOs in the areas of core training curriculum, treatment protocols, recommended drug lists and determine the extent to which this uniformity is desirable/feasible.
5. Review PVO plans for and progress toward providing training for female health workers. Make recommendations for accelerating the recruitment and training of women, recognizing the cultural sensitivity of the exercise.
6. Determine the comparative costs of training personnel and supplying facilities at equivalent levels among different PVOs.
7. Identify procedures to improve the verification of the facilities and the operational status of the health posts and clinics.
8. Assess the coordination efforts between the PVOs and the Coordination of Medical Committee (CMC) to conduct medical clinic assessments inside Afghanistan.

Part IV: Rural Assistance Project Specific

1. Evaluate the performance of the IRC as the overall managing agent of the PVO subgrantees relative to a) PVO subgrant selection; b) financial monitoring; c) administrative support; d) project activity monitoring; and e) program assessment.
2. Determine if the IRC is the most efficient and cost effective mechanism for managing the subgrants under this project. Recommend if a threshold should be set for funding levels made to subgrantees above which A.I.D. should make direct grants; and if IRC should be used exclusively to manage grants to foreign PVOs.

3. Determine if the project should continue to move away from the cash for food activities. Establish the extent to which this objective has already been met.
4. Examine the engineering capabilities of the PVOs and establish the kinds and levels of engineering activities A.I.D. should support.
5. Establish the prospects for the evolution of this project into more rehabilitation oriented activities in the near to medium term.

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E-1

ANNEX E
INDIVIDUALS CONSULTED FOR THE EVALUATION

1/2

ANNEX E

INDIVIDUALS CONSULTED FOR THE EVALUATION

A.I.D./W

Elizabeth Kvitashvili
Howard Sharlock
Christina Loken
Nick Studzinski
Richard Whitaker

A.I.D./Rep Islamabad

Larry Crandall
Jack Miller
John Gunning
Gary Lewis
Phillip Church
Tom Eighmy
Curt Wolters
Diana Swain
Doug Palmer
Dimitria Arvanitis
Susan Lenderking

A.I.D./Rep Peshawar

Hank Cushing
Al Nehoda
Diana Stiles
Riffat Saddar
Asef Ikram

AIG/Ministry of Reconstruction

Engineer Muqtar
Eshanullah Mayar

AIG/Ministry of Public Health

Dr. Fatimi
Dr. Rabbani Popal

IRC

Roy Williams
Sarah Jackson
Margaret Gee
Tom Yates
Steve Segal

IMC

Todd Peterson
Margaret Bowden

IRC/RAP

Regine Mounier
Andrew Wilder
Mr. Qaiser

Afghanaid

Peter Rees
Mr. Hamidullah
Jason Jones
Mark Pont

AFRANE

Sylvie Gallot
Shahir Zahine

CARE

Joe Steele
Bill Huth

CHA

Abdul Salaam

CMC

Jeff Paulsen

GAC

Reinhold Eroes
Michel Mueller

GOP/CAR

Sayed Akhtar

GOP/A.I.D. Liaison

Mr. Omar

Freedom Medicine

Nancy Jamison
Lynn McFadden
Rene Stills
Susan Purdin
Maryann Javed
Denise Natale

MCI

Jerry Dines
Engineer Ayubi
Myron Jesperson
Mella Aatto Leiter
Mr. Faruq

MSH

Dr. Bill Oldham
Dick Johnson
Dr. Jonathan Quick

MTA/MRCA

Christian Gravet
Dr. Philippe Sarou
Mr. Feray
Dr. Philippe Boidin

Mercy Fund

Anne Hurd
Steve Masty

Save the Children/US

Jim Soules
Sultan Aziz
Paul Fishstein
Jan Goodwin
Mark Williams

Solidarité Afghanistan

Patrick Brizay

Swedish Committee

Anders Fange
Dr. Haider Raza
Douglas Saltmarshe

UNDP

Bob Eaton
Wayne Bauman

UNHCR

Anne-Willem Bijleveld
Juliet Vergos
Michel Gabaudon
Peter LeClerc

VITA

Engineer Sediq

WHO

Dr. Sharon MacDonald

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SECTION-C

SCHEDULE

&

SCOPE OF WORK

A. Background

A.I.D. has supported PVOs since the Afghanistan Cross-Border program began in 1985. Currently, the Mission has two PVO projects: PVO Co-financing and Rural Assistance. It is expected that A.I.D. will provide \$14.0 million in both FY 1989 and 1990 to support ongoing and new PVO activities for Afghanistan.

The PVO Co-financing project was authorized in March 1986. It currently has an authorized funding level of \$35.0 million and a PACD of March, 1991. Selection criteria under this project are intentionally broad and flexible. The Project originally supported activities in health, cash for food, education and agriculture. It was focused mainly on health activities since the establishment of the Rural Assistance project, but a planning grant to CARE, Inc., for a new food for work project was recently funded. The Mission is reviewing two proposals for new, unregistered refugees, and additional activities may be considered, especially when refugees begin to return to Afghanistan. Grants awarded through the PVO Co-financing project have been made directly by A.I.D. through intermediaries, specifically, the International Rescue Committee and Americares.

The Rural Assistance Project (RAP) was authorized in May, 1988 for \$10.0 million and has a PACD of September, 1990. Its three components include: 1) grants to families for emergencies caused by military activities or natural disasters; 2) grants for village assistance with an emphasis on rural income and improved productivity; and, 3) grants for vanguard resettlement activities. The RAP is administered by the International Rescue Committee, which review proposals and recommends to A.I.D. approval or disapproval, monitors subgrantee activities financed under the project and assists the subgrantees in strengthening their administrative capabilities.

B. Scope of Work

Part I. Project Objectives

1. Review the past, present and planned roles of PVOs in helping to implement certain elements of the CBHA program.
2. Examine the A.I.D. financed activities of each PVO and determine the degree of success each has achieved in meeting stated objectives. Recommend ways in which each activity can be strengthened in critical areas.
3. Review and evaluate the monitoring, accountability and internal evaluation systems of each PVO and assess the extent to which each has adopted creative operational systems beyond the basic input-output model.

4. Review and identify the causes for the recently growing level of objections by the Afghan Interim Government (AIG) and the Government of Pakistan (GOP) to PVO activities inside Afghanistan. Identify the short and long-term implications for a continuation of this trend of objections.

Part II. General Effectiveness

Subpart A: A.I.D. Performance

1. Review existing mechanisms used by the O/AID/Rep to finance and manage PVOs and recommend changes/alternatives to improve them. These include direct grants and Cooperative Agreements with intermediaries to which varying amounts of authority are delegated.
2. Review the current mix of PVO activities to determine whether A.I.D. has set priorities and allocated funds in a manner proportionate to the needs inside Afghanistan and to the PVO community's ability to respond to those needs.
3. Determine the effectiveness of the A.I.D. Project Officers as catalysts for effective communications and coordination among PVOs and between PVOs and the major sectoral contractors, especially with regard to resource and information/data sharing.

Subpart B: PVO Performance

1. Review and evaluate the field coordination and collaboration among the various PVOs and determine the degree of effectiveness in avoiding unnecessary overlap and duplication of effort and in achieving standardized selection criteria and operational approaches.
2. Review and determine the effects of the relatively high rate of turnover among expatriate technical personnel on PVO project activities. Ascertain the level of success of the PVOs in recruiting expatriate technical staff for tours of duty exceeding six months.
3. Determine and evaluate the degrees and levels of active Afghan technical involvement in PVO activities. Determine if Afghans are sufficiently involved in data collection and analysis, monitoring and evaluation. Determine if data collected in the field are analyzed locally.
4. Review and determine whether PVOs are complying with the monitoring and evaluation guidelines provided by the Mission (i.e. are PVOs submitting timely and standardized periodic reports to the Mission? Do these reports present organized and logically presented data?)
5. Review and determine the extent of effective coordination and collaboration of activities between the PVOs and principal A.I.D. contractors in major health, education and agriculture sector projects.

6. Determine the extent of coordination of activities by participating bodies on both sides of the border (i.e. administrative operations in Pakistan and technical operations in Afghanistan). Identify road blocks to more effective coordination.
7. Review and assess the relationship between the headquarters and the field operations of each PVO. Ascertain if the field office has been given adequate authority. Identify the percentage of the budget allocated to headquarter operations and ascertain if this level is justifiable.
8. Identify the level of success PVOs have had in diversifying their funding sources and decreasing their dependency on the USG for financial support.
9. To the extent possible, evaluate the impact of the activities implemented by participating PVOs.
10. Review and determine the degree of overlap with similar activities, using the same PVOs funded by other donors (UN, etc.).
11. Determine the extent to which the U.S. PVOs have been able to overcome the handicap caused by the prohibition of A.I.D.-funded Americans entering Afghanistan. Assess the capacity of the U.S. PVOs to absorb and effectively use increased levels of USG resources.

Part III: Health PVOs Specific

(The following items in the SOW are specific to the health activities of the PVO Co-financing Project)

1. Evaluate the adequacy and effectiveness of the training programs, including the curriculum content and training technique and the location, number, level and types of facilities used for training.
2. Review and determine the adequacy of PVO follow-up with former trainees and beneficiaries, to the extent possible, including, but not limited to, patients inside Afghanistan.
3. Evaluate the appropriateness, adequacy and effectiveness of the types and levels of health services and commodities provided.
4. Ascertain if there is uniformity among health PVOs in the areas of core training curriculum, treatment protocols, recommended drug lists and determine the extent to which this uniformity is desirable/feasible.
5. Review PVO plans for and progress toward providing training for female health workers. Make recommendations for accelerating the recruitment and training of women, recognizing the cultural sensitivity of the exercise.
6. Determine the comparative costs of training personnel and supplying facilities at equivalent levels among different PVOs.

7. Identify procedures to improve the verification of the facilities and the operational status of the health posts and clinics.

8. Assess the coordination efforts between the PVOs and the Coordination of Medical Committee (CMC) to conduct medical clinic assessments inside Afghanistan.

Part IV: Rural Assistance Project Specific

1. Evaluate the performance of the International Rescue Committee (IRC) as the overall managing agent of the PVO subgrantees relative to a) PVO subgrantee selection; b) financial monitoring; c) administrative support; d) project/activity monitoring; and e) program assessment.

2. Determine if the IRC is the most efficient and cost effective mechanism for managing the subgrants under this project. Recommend if a threshold should be set for funding levels made to subgrantees above which A.I.D. should make direct grants; and if IRC should be used exclusively to manage grants to foreign PVOs.

3. Determine if the project should continue to move away from the cash for food activities. Establish the extent to which this objective has already been met.

4. Examine the engineering capabilities of the PVOs and establish the kinds and levels of engineering activities A.I.D. should support.

5. Establish the prospects for the evolution of this project into more rehabilitation oriented activities in the near to medium term.

July 2, 1990

TO: The Files
A. (306-0201)
B. (306-0208)

FROM: Curt Wolter²⁵ Evaluation Officer

SUBJECT: Final Version of the Joint PVO Co-Financing and Rural Assistance Project Evaluation.

1. The final version of the evaluation document is a decided improvement over the final draft. In its revision DAI took most of the Mission's and PVO's feedback on the draft into consideration which resulted in a sharpening of issues, clearer presentation, a better analytical presentation, and an improved layout of the document.

2. Unfortunately, the contractor failed to adequately address three items clearly spelled out in its scope of work:

"Review and identify the causes for the recently growing level of objections by the Afghan Interim Government (AIG) and the Government of Pakistan (GOP) to PVO activities inside Afghanistan. Identify the short and long-term implications for a continuation of this trend of objections."

"Determine and evaluate the degrees and levels of active Afghan technical involvement in PVO activities. Determine if Afghans are sufficiently involved in data collection and analysis, monitoring and evaluation."

"Review and assess the relationship between the headquarters and field operations of each PVO. Ascertain if the field office has been given adequate authority. Identify the percentage of the budget allocation to headquarters operations and ascertain if this level is justifiable."

It is not clear why this is so, especially since DAI's attention was drawn to these omissions in the mission's comments on the contractor's final draft.

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memorandum

DATE: December 18, 1989

REPLY TO
ATTN OF: O/AID/Rep

SUBJECT: Final Draft of the Evaluation Report on PVO
Co-Financing and Rural Assistance Projects.

TO: DAI

1. The mission finds the evaluation report uneven, insufficiently conceptualized and disorganized.
2. An important factor in the O/AID/Rep's decision to have these two projects jointly evaluated was to review and assess how the mission works with PVOs in general, how effective this relationship is, and what options it has in improving, streamlining and managing PVO-funded activities. The report in essence evaluates the PVO Co-financing and the Rural Assistance projects separately, failing to pull together issues and questions relating to overall O/AID/Rep - PVO relationships, assistance modalities, emphases and management frameworks. This is both a conceptual failure and an organizational shortcoming.
3. The scope of work for this evaluation clearly states:
"Review existing mechanisms used by the AID/Rep to finance and manage PVOs and recommend changes/alternatives to improve them. These include direct grants and cooperative agreements with intermediaries to which varying amounts of authority are delegated."

The evaluation report skirts this important element. The evaluation team apparently chose to zero in on the existing RAP mechanism only, suggesting managerial/technical/operational improvements therein. It did not address the macro-management issues and conceptual alternatives to the several existing RAP cooperative agreement and the PVO project mechanisms.

4. As it now stands, the report discusses PVO issues only in the context of the RAP; it does not address them at all with respect to the PVO Co-Fi Project. This is neither appropriate nor what the AID/Rep requires in its deliberations on determining where we go from here. We recommend the team consider the extent to which its PVO discussions under the RAP section also pertain to the PVO Co-Fi

Project, and reorganize/revise the report in three sections. One should be on the use of PVOs, one on the RAP and one on PVO Co-Fi -- which is not just a health equivalent of the RAP.

With respect to the PVO Co-Fi Project, the report should discuss the current validity/utility of the PVO AAM, the existing direct grant and IRC cooperative agreement mechanisms, and possible alternatives. (The report should note and comment on the differences between the two IRC cooperative agreements, one under each project.)

5. Further to the PVO Co-Financing Project, in contrast to the RAP, a conceptual framework was not included in the project design; activities, instead, were to be addressed against specific PVO proposals in a variety of sectors. The mission's health staff over the past year has gradually developed a health PVO strategy, against which it guides and measures PVO proposals in the health sector. However, this is a part of the mission's health sector conceptualization rather than a part of the PVO project design. In addition, the mission has just prepared a Democratic Pluralism strategy which is now in Washington for review. This study will be used as guidance for considering PVO proposals in this area. Sectoral guidance thus is provided as a part of a project design in the RAP, but through sector strategies or Mission responses to PVO initiatives in the case of the PVO Co-Fi Project.

6. After discussing each project, the team should address their respective approaches and whether they should usefully remain two projects. A third alternative would be to have a PVO component in the sectoral projects (Health, Education and Agriculture). (This concept was recently approved for our new Narcotics Project, but has not yet been tried.) We discussed these project design ideas with the team, and would appreciate their comments. In the context of future A.I.D. support for PVOs, the team should assess to what extent the availability of U.N. funds to support the implementation of PVO activities is contributing to increased absorptive constraints for the PVOs. Should A.I.D. be exploring a reduction in funding for PVO activities given the availability of U.N. resources?

7. The following rearrangement and revision of existing materials is one way you might reorganize the report so that it focuses on the Mission's use and relations:

- A. Preface
- B. Background
- C. Executive Summary
- D. Recommendations

- I. Cross-sectoral PVO-funded activities
 - A. Overall issues
 - B. Design issues
 - C. Objectives and impact indicators
 1. The role of PVOs
 2. Coordination
 3. Monitoring
 - D. Implementation issues
 1. PVO performance
 2. IRC performance
 3. AID/Rep performance
 - E. Main findings and recommendations
- II. Rural Assistance Project
(rest of section as under I, A-E)
- III. PVO Co-financing Project
(rest of section as under I, A-E)
- IV. Should there be one, two or more PVO projects and/or subprojects

Bibliography

Annexes

8. The report further fails to adequately treat other important elements in the scope of work:

"Review and identify the causes for the recently growing level of objections by the Afghan Interim Government (AIG) and the Government of Pakistan (GOP) to PVO activities inside Afghanistan. Identify the short and long-term implications for a continuation of this trend of objections."

"Determine and evaluate the degrees and levels of active Afghan technical involvement in PVO activities. Determine if Afghans are sufficiently involved in data collection and analysis, monitoring and evaluation."

"Review and assess the relationship between the headquarters and field operations of each PVO. Ascertain if the field office has been given adequate authority. Identify the percentage of the budget allocation to headquarters operations and ascertain if this level is justifiable."

9. Corrections:

a. Background (p.2, last para) should read:

"As part of its ongoing PVO Co-financing Project support, the Office of the AID/Rep obligated \$6.6 million in FY 1988 and \$7 million in FY 1989 for PVO grants. All but one grant were for health activities. In FY 1990, however, \$900,000 is programmed for educational and democratic pluralism activities. IRC authorized for types of grants: etc."

- b. IRC Performance (p.9, last para): Note that funding of PVOs not registered with AID is a non-issue. This is an Agency requirement only for grants, not for subgrants for which the grantee is responsible. The issue is getting other donors to pick up increasing amounts of PVO financing.
- c. The role of PVOs in Rural Assistance; Background section (pp 23 - 24, last page): eliminate sentence reading "In hindsight, assistance programs that appeared appropriate in early 1989, now appear ambitious and ill-advised." We suggest this because the sentence is vague, as specific types of assistance programs appearing "ill-advised" are not identified.
- d. Management Structure; Findings section (p. 43, last para): Note that the PVO Co-financing project already is a multi-sector source of direct grant funding. This must be rewritten.
- e. Conclusions and Recommendations; Recommendations section (p. 77): On p. 74 Dr. McGill addresses the issue of "sustainability." We suggest that in the recommendations section the issues of salaries and distribution of free medicines be subjects of recommendations as well.

10. We attach copies of memoranda and letters with comments on the subject evaluation, received by the O/AID/Rep. In the interest of timing, these are essentially "raw comments" (i.e. unedited); the team should nonetheless review these comments and observations, and take them into account.

Dick Johnson, MSH to Doug Palmer (Dec 13, 1989)
IRC to H. Cushing and A. Nehoda (Dec 13, 1989);
Doug Palmer to Tom Eighmy (Dec 12, 1989)
Al Nehoda to Curt Wolters (Dec 12, 1989)
Tom Eighmy to Curt Wolters (Dec 14, 1989)
Freedom Medicine to Doug Palmer (Dec 12, 1989)
Todd Petersen (IMC) to Doug Palmer (Dec 13, 1989)

memorandum

DATE: December 14, 1989
REPLY TO
ATTN OF: T. Eighmy 
SUBJECT: PVO Evaluation

TO: Curt Wolters

In general, in the health sector we received a medically competent review of the major PVO grantees. Most of this we knew before. Specifically:

1. Please request Poulin to include a frank presentation of the results of his inquiry among the PVO's as to their inclusion under some form of MSH managed PVO umbrella. We know he asked the question and we know basically what the answers were but these are not included in the existing report.
2. Can Poulin/McGill make any recommendations on a future management structure of O/AID/Rep's health program which takes into account effective implementation concerns across the health sector (eg. relative costs per trainee and per facility among PVO's and between PVO's and MSH, staff recruitment, visa registration and N.O.C. issues, relative staff pay levels, uniform pharmaceutical procurement, specialization of training, relative quality of training.)
3. Poulin's and McGill's verbal presentation recommended continuation of the current management structure of individual grant's for the large American PVO's, and the IRC blanket for European and smaller PVO's. If they still believe it, they should say so in the final report. If they have changed their mind they should say so.

This office has already distributed relevant parts of this draft to IMC, FM, MCI, and MSH. (IRC already has a copy). Based on today's meeting, we will use discussion of the final report as a rationale for convoking the PVO's in January, prior to the MSH review.

cc: D. Palmer, Health Development Officer
D. Arvanitis, Asst. Project Officer
J. Miller, Dep AID/Rep
L. Crandall, AID/Rep

memorandum

DATE: 12 December 1989

REPLY TO
ATTN OF: A.J. Nehoda, RAO/AF, Peshawar

SUBJECT: Comments on Rural Assistance Project Evaluation (as Requested in Your
Memo of 6 December 1989

TO: Curt Wolters, O/AID/REP, Islamabad

I have read the revised evaluation report and continue to find the suggestions and recommendations made by DAI to be admirable in objective terms. My concerns lie more with the implications inherent in adopting many of the recommendations. I am basically opposed to any recommendations which complicate, rather than simplify, procedures; which increase administrative costs, rather than contain them; and which focus on improvement of qualitative, rather than quantitative data or information collection. All of our projects, not just RAP, must make significant improvements in verifying quantitative information.

Separate comments from IRC on the report are appended here.

memorandum

DATE: December 12, 1989

REPLY TO
ATTN OF:

Doug Palmer, AID/REP *Doug Palmer*

SUBJECT:

Remarks on the Final Draft Evaluation of the Health PVO's
Funded Under the PVO Co-Financing Project

TO:

Tom Eighmy, AID/REP

John McGill's slice of the evaluation is somewhat incomplete, unnecessarily repetitive, and occasionally unclear; however, for the most part, the recommendations are sound.

Below, I will provide remarks separately for the individual PVO's evaluated: MCI, FM and IMC, then comment on McGill's overall observations and recommendations.

1. MCI's existing program was evaluated to be good to excellent.

MCI, however, has plans to expand its on-going TB pilot program in Helmand, which McGill rightfully cautions against, until MCI medical staff are adequately trained and the needed supervisory and supply systems are established to support a relatively sophisticated treatment program. AID/Rep should not fund MCI's proposed TB program at this time. (Overall, I believe it may be too early in the "reestablishment" of the Afghan health delivery system to support any effective vertical program, such as TB, EPI, etc.)

McGill recommends retraining the first two MCI classes and the nurses working for MCI, rather than training new health providers. I agree entirely, but I am not clear what he recommends to be included in the retraining. Nor am I clear why he suggests a one-year training program, rather than, say 8 months or 18 months..? (More about training is given below.)

2. Dr. McGill's assessment of FM's plans to transfer its program over to MOPH is the same as mine: there is a lot of details to be worked out yet, and FM's timetable is too short to provide a reasonably good chance that the program can be transferred successfully. McGill counsels better planning: (a) delay the refresher course opening to insure preparedness, (b) hold one refresher course at a time -- as beginning a new program while at the same time transferring the program is risky, and (c) obtaining an agreement (written preferably) from the Swedish Committee or whoever (for pharmaceutical supplies, etc.) - as needed - for continued support of FM's, and soon-to-be, the MOPH health workers. (McGill

terms FM's
OPTIONAL FORM NO. 10
(REV. 1-60)
GSA FPMR (41 CFR) 101-11.6
5010-114
*U.S. GPO: 1988-401-244/20682

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graduates "mid-level" health workers; I believe they should more accurately be considered BHWs.)

McGill states that FM is the first to begin development of a comprehensive retraining course; he assesses the, yet, incomplete course to be good. He states that there is a tremendous need for retraining of mid-level training programs (I agree and would add BHWs too). If FM's retraining program is good, it should be considered for use by all the PVOs and MSH - modified as needed. We should guard against the funding of separate retraining courses.

3. IMC's program is assessed to be "very solid." Dr. McGill recommends, however, that the outpatient care at Nasr Bagh be "similar to a 'well designed', feasible clinic in Afghanistan." Both I and Todd Peterson believe McGill's recommendation to mean that the OPD should not be sophisticated, that it should be more realistic to actual conditions in Afghanistan. If this is what McGill means, I agree.

Carol Phillips should look at McGill's recommendation on laboratory testing. (More about lab inputs into the program is given below.)

4. Dr. McGill lobbies for the continuation of CMC as a coordination body for the cross-border participants. I strongly agree, if CMC's management and technical expertise is strengthened, and CMC members come up with clear, relevant, "do-able" tasks. (See my 10/89 memorandum on the subject.) McGill lists some important tasks needed to be accomplished: (a) standardization of health facility definitions, (b) the mal-distribution of health facilities in Afghanistan and a plan to rectify the problem, (c) re-training design, etc.

I do not agree with McGill's recommendation that CMC limit itself to a coordination role, restricted to monitoring. If we are to reconsider CMC funding we would want a stronger role for CMC -- more one of coordinated planning, than passive promotion of interaction.

I would recommend that we ask the CMC membership to come up with a detailed annual work plan of mutually agreed upon tasks and a time frame to come up with plans of actions/solutions to proposed tasks. We, then, can make a final decision on whether we want CMC to wither away. I believe the AID/Rep health program needs a CMC. ACBAR

cannot pick-up the cudal and WHO is not in a strong position to do a good job of it.

5. Overall Project Issues:

(a) Quality of Program Graduates. In this section McGill seems to be saying that there is no role for the BHW because a 3-month trained health worker is not competent to deliver relatively sophisticated health care. I disagree. There is a continued need for a BHW at the lowest level of the health pyramid. To eliminate the BHW, and concentrate on mid-level providers, would be to insure that a great majority of the Afghan population would have no contact with a health care provider, and that a very expensive system would be developed - a system not affordable by a poor country, by Afghanistan.

I agree with McGill that it appears that there is just too many free drugs (both type and amount) going into Afghanistan. This is one factor leading to misuse. This area should be looked into further.

(b) Retraining is obviously needed. The PVO's and MSH should coordinate, plan and - where possible - mutually retrain its workers, together to save costs. AID/Rep should require this in our agreements with the different entities. Perhaps the Thal facilities can be used by all for this...?

(c) Quality versus Quantity: I agree 100% that it is now time to stop producing new health workers, especially BHWs, until a clear assessment is made as to future needs. This assessment includes the need to restrict the opening of new health facilities. AID/Rep should require all of our grantees to provide us with clear, detailed proof that a new health worker/facility is needed before we agree to fund such. This restriction should be made part of our revised agreements with them - particularly those of IMC and MSH.

Quality should be targeted, but, as earlier stated, with an eye to collaborative activities to achieve such (both to save costs and to mold the workers into a standardized health system) and to achieve an affordable health care system.

(d) Sustainability (as above) is very important and must be planned for now.

(e) Laboratory efforts - McGill mentions the problems encountered when attempting to introduce good laboratory techniques inside at the clinic level. His observations are borne out by monitoring reports (CME). Like the development of most vertical programs, I don't believe the Afghan system is ready, and we are wasting money on trying to establish functioning labs in all the very

few sites.

I've given relevant portions of the draft evaluation report to IMC, MSH and FM. I've asked for any comments those organizations may have. I will FAX such to you if/when received.

MEMORANDUM

DATE: December 13, 1989
FROM: Regine and Andrew, IRC
TO: H.B. Cushing & Al Nehoda
SUBJECT: USAID RAP Evaluation Report

As RAP was not given sufficient time to review and comment on the evaluation report, this memo does not represent a comprehensive analysis of the report and will only address what are felt to be the most important issues. In general, while there are many factual errors in the body of the RAP evaluation report, RAP has few fundamental disagreements with the reports conclusions and recommendations. The following comments, however, can be made:

I. LACK OF HISTORICAL PERSPECTIVE

Although there is an acknowledgment of improvement in the quality of proposal and report writing, the report largely fails to evaluate the progress made by the P.V.O.s and by IRC/RAP in improving program administration, proposal and report writing, and monitoring. The evaluation team judged what is being done today without paying much attention to what was being done a year ago. This not only resulted in their failing to appreciate the progress made by PVOs and IRC/RAP, but also the changing attitudes and requirements of USAID during the course of the year. For example, the Soviet troop withdrawal led many to believe that the war would be over soon, and that the time had come to replace emergency programs like distributing cash for food with well structured, and professionally administered P.V.O. projects. Such a change of emphasis could not occur overnight. After 6-8 months, however, most PVOs had made tremendous progress towards adapting to the changing requirements of donors. For example, all PVOs have taken some or all of the following steps to strengthen their programs:

- 1) Doubled or tripled their expatriate staff (including IRC/RAP) to manage the increasing demands of donors;
- 2) Hired professional accountants and trained administrators;
- 3) Introduced computers for accounting, word processing, and data base purposes;
- 4) Hired engineers and/or agronomists to strengthen the technical components of their projects;
- 5) Strengthened the monitoring components of their projects and increased oversight over projects through the longer term presence of Afghan or expatriate staff at project sites; and
- 6) Improved the coordination of their activities through participation in ACBAR.

In June 1988, we received two-page proposals for several hundred thousand dollar projects. Reports were sketchy and some what misleading. No monitoring whatsoever existed and the idea was new and disturbing to some P.V.O.s. The idea of USAID to monitor projects after four years of giving grants on the basis of trust was not well received. Considerable time was spent by IRC/RAP convincing PVOs of the necessity of monitoring and now its importance is recognized by all RAP-funded PVOs.

II. MONITORING

The evaluation team criticizes the poor quality of monitoring by P.V.O.s and by IRC/RAP.

1) P.V.O monitoring

The evaluation team's comments on PVO monitoring are too sweeping and fail to distinguish between those who are doing a good job and those who aren't, between those who have to monitor in Herat and those who have to monitor in Nangahar, etc... Again, no mention was made of the progress made in PVO monitoring since one year ago or of the failure of virtually all agencies (including USAID) to establish effective monitoring programs.

2) IRC/RAP monitoring

The history of the RAP program has been overlooked by the evaluation team while arriving at their conclusions. The Cooperative Agreement was signed in June '88 and IRC/RAP has really only received two rounds of proposals (in the summer of 1988 and the summer of 1989). For the first several months as projects were getting underway there was not much to evaluate. IRC/RAP then had to deal with the reluctance of several PVOs to be monitored as they had received money without any kind of checking in the past.

The evaluation team does not emphasize sufficiently the difficulty of finding qualified monitors. It is not easy to find non-American expatriates, fluent in Pushto and/or Farsi, with an agricultural and engineering background, with prior experience in Afghanistan, and who are willing to spend extended periods of time in Afghanistan. It is also difficult to find qualified Afghan monitors with sufficient technical skills, who are politically acceptable, and who are willing to travel to various parts of Afghanistan. IRC/RAP has made a serious effort to develop a monitoring team although admittedly with limited success. While formal monitoring has not been successful, this does not mean that RAP has remained oblivious to the status of the PVO projects it is funding. The evaluation team did not take into consideration the informal monitoring through briefing and debriefing of mission teams, through on-going discussions with PVOs, and through the "grape-vine," which keeps RAP relatively well-informed regarding the PVO projects.

III. EVALUATION TEAM RECOMMENDATIONS

RAP supports the following evaluation team recommendations:

- 1) That substantive review be allowed to RAP and that specialized staff be hired for this purpose.
- 2) That IRC/RAP monitoring and P.V.O monitoring be improved.
- 3) That PVO proposals and reports be improved.

Nevertheless, RAP wishes to stress the followings:

- 1) Any changes in policy, criteria, and requirements should be dealt with within the spirit of the Cooperative Agreement -- which is to say cooperatively with RAP. AID/rep or ADO should not be in a position to dictate policy to IRC but should consult with IRC so that mutually agreed upon decisions can be reached.
- 2) The criteria given in Annex C ("Suggested criteria for RAP sub-grant approval) are somewhat useless as most of them have been already adopted. Moreover, many of the criterion have more to do with how to write a proposal (i.e. verify the existence of emergency) rather than with selection criteria.

It would be a mistake to require a contribution of 25% of the cost of a project before approving a Village Assistance grant. It is dangerous to get into the game of setting numerical benchmarks as the situation varies from district to district in Afghanistan. While one area may be able to make such a contribution, others may not.

- 3) It is questionable if IRC/RAP should adopt U.N. the format. Should RAP use the same proposal format for a \$1 million dollar proposal as UNDP does for a maximum \$70,000 proposal?

IV. FACTUAL ERRORS

Page 8, Par. 2, line 9:

Read: Finally, there is no independent monitoring.

Should read: Finally, there is no satisfactory independent monitoring.

Page 2, P 2:

Read: In June 1988, USAID signed a three year Cooperative

Should read: ... two year...

Page 2, P 2:

Read: This agreement authorized IRC to provide and administer grants to qualified P.V.O (i.e P.V.O registered with USAID).

Note: The fact that P.V.O.s have to be registered with USAID is not a condition of the Cooperative Agreement. IRC/RAP adopted this as a prerequisite with the authorisation of USAID.

Page 6, P 3:

Read: Takhar

Note: IRC/RAP does not fund a Solidarite Afghanistan project in Takhar.

- Page 7, P 1:
Note: Solidarite Afghanistan has implemented 6 months to 1 year projects in Kandahar and Wardak where they have teams based on a long term basis.
- Page 7, P 2:
Read: Afghanaid mainly work with commander Massoud.
Note: Only 50% of Afghanaid funds from RAP were allocated to the Panjshir Valley which is controlled by Massoud.
- Page 7, P 2:
Read: Afrane proposals to be notably lacking technical content.
Note: RAO engineer found all proposals from all P.V.O.s to be lacking in technical content. In terms of technical content, Afrane's were among the best proposals that RAP has received.
- Page 8, P 3:
Read.....Strong interest in income generating.
Note: Judging by the proposals submitted to RAP, PVOs have not shown a strong interest in income generating projects.
- Page 8, P 4:
Read: ...Solidarite Afghanistan sends an expatriate with each mission who stays until the activity is completed.
Should read: ...Solidarite Afghanistan tries to send.....
- Page 10, P 2:
Read: Requirement.....P.V.O. receive AIG approval before submission to IRC/RAP.
Note: This is not an IRC/RAP requirement.
- Page 11, P 1:
Note: This paragraph is misleading. The previous experience IRC (i.e. before RAP's creation) gained through the management of the co-financing projects was not much experience to draw upon as RAP is structured very differently.
- Page 11, P 5:
Read: IRC/RAP had hired an expatriate monitor who produced useful reports but unfortunately did not stay long.
Should read: Unfortunately, the expatriate monitor did not produce reports and was consequently asked to resign.
- Page 12, P 7:
Read (under Recommendations): In order to activate.....AID representative should establish.
Should read.....AID representative and IRC/RAP.
- Page 26, P 3:
Read: European P.V.O.s have been engaged in much simpler relief.....
Note: To RAP's knowledge there is today little difference between the technical abilities of European and American P.V.O.s.
- Page 33, P 2 & 3:
Read P 2: The evaluation team found little evidence of substantive coordination between RAP sub grantees and contractors.
Note: VITA and IRC sub-grantees coordinate their activities through ACBAR.
- Page 38:
Read: RAP monitoring (Pi last sentence): This last sentence(unfortunately, the monitor) should be deleted. While it may have been unfortunate for the monitor (and for the evaluation team) it was not unfortunate for RAP.

Page 38 -- USAID monitoring:

Note: RAP has never been informed by AID representative of important standards for identifying and mapping project sites, etc..., and is not aware of their existence.

Page 44 Recommendation no. 2:

Note: There is no need for a revision of the Cooperative Agreement as the activity suggested is not forbidden by the Agreement.

Page 44 Recommendation no. 4:

Note: Long term development projects (over one year) are outside the scope of RAP and should remain so.

Page 46 Recommendation (Top of page):

Note: IRC, after discussing policy issues with AID/Rep., should not have to go back to ADO for ongoing grants. This will undoubtedly complicate and lengthen the procedure. IRC/RAP understands USAID's need to have P.V.O. projects conform with USAID policy. Nevertheless, after discussing and arriving at policies with RAP, RAP should be permitted to get on with managing the projects.

V. CONCLUSION

As mentioned in the beginning, RAP has few fundamental disagreements with the recommendations of the evaluation team. It is clear to all parties concerned that monitoring and reporting need to be improved. Nevertheless, we must be careful not to become so concerned with increasing the efficiency of the RAP process, by placing newer and better requirements on the PVOs, etc., that we forget about the end of getting the job done in Afghanistan.

Freedom Medicine

Providing Health Care Through Training

December 13, 1989

Mr. Douglas Palmer
AID Representative/Health & Education
USAID
Islamabad, Pakistan

Reference: Evaluation Report: PVO Co-Financing & Rural Assistance Projects

Dear Mr. Palmer:

Thank you for allowing me the opportunity to comment on the joint evaluation conducted by USAID and Development Alternatives International (DAI) during the month of November, 1989. I have generally found the evaluation teams to be professional, fair and knowledgeable, and over the years the teams' observations have provided this organization with valuable insight into how our programs might be better managed and more efficiently operated. In light of the significant changes which Freedom Medicine has undergone over the past six months, the timing of the evaluation was particularly opportune and the results most gratifying.

With regards to the evaluation report, I would like to offer the following for your consideration:

p. 59, paragraph 1, lines 6-12: The report noted that Freedom Medicine's Afghan physicians and expatriate staff jointly developed the competency-based curriculum, and that this approach was characterized by active rather than passive learning.

Comment: More elaboration on what differentiates a "competency-based" approach to learning from one which focuses on theoretical knowledge is necessary in order to appreciate the complexity of the task of designing such a curriculum. The curriculum preparation included: identification of learning needs, definition of skills to be mastered by students, selection of knowledge/learning objectives for each module, the planning and design of practical applications through which the students would achieve mastery of skills and a mechanism through which students' progress would be evaluated.

Traditionally, the Afghan understanding of the educational realm is that learning is imparted from a teacher when s/he lectures to students. With this in mind, the objective of curriculum development exercise was two-fold: the

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production of a high-quality advanced/refresher program for paramedics, and the establishment among the Afghan staff of a basic understanding of competency-based training and a concurrent ability to design such programs themselves.

Because "active" learning is a foreign concept to Freedom Medicine's Afghan physician/instructors, the time required for them to design a course utilizing this methodology is understandably longer than would have been the case if the curriculum development had been left exclusively to the expatriate staff. Likewise, much revision and guidance was necessary during the process to insure that both objectives were achieved to the greatest extent possible; this too contributed to the length of time necessary for the course to be prepared.

The curriculum-development ability achieved by the Afghan physicians in Thal is being reinforced through the Training of Trainers (TOT) course currently underway; the TOT program provides an added measure of insurance that the advanced course will be taught as it has been designed, with an emphasis on skill mastery and practical application of knowledge.

p. 59, paragraph 3, lines 16--22: The report stated that course materials presented for review were not consistently of high quality.

Comment: At the time of this evaluation, the Medical Coordinator had just returned from a six-week home leave and had not yet had an opportunity to collect and review the work which had been completed in her absence. The course materials which were provided to the evaluator were ones which had been completed by the Afghan staff prior to her departure. As was mentioned above, revisions were made on an ongoing basis until the materials were of sufficient quality to comply with program requirements.

I will be happy to provide you with the most recent drafts of the curriculum upon request.

p. 60, paragraph 1: The report described the recruitment, screening and selection process for course applicants and offered suggestions pertaining to the development and application of the entrance examination.

Comment: The written portion of the qualifying examination took place at the Ministry of Public Health Training Institute on December 10, 1989. Ninety-eight (98) candidates participated in the examination; analyses of their performance on the written and oral components of the test will provide further indications of advanced/refresher training needs.

In light of the diversity of the pool of candidates (graduates from a number of different training programs were tested), much interest has been expressed in studying the within- and between-group performances. Upon completion of the initial evaluations of these examinations, Freedom Medicine will conduct just such an analysis and will make that information available to interested as requested.

p. 60, paragraph 2, lines 14-17: The report indicated that the issue of who would serve as instructors for the course in the future required clarification. It was uncertain whether Freedom Medicine's Afghan staff in Thal would carry out the bulk of the teaching or if instructors would be provided through the Ministry of Health's Training Institute.

Comment: Freedom Medicine's Afghan staff in Thal will serve as the core instructors for the advanced training program. In addition, the Ministry of Health has identified two Afghan physicians for involvement in the course as well. Freedom Medicine has required that before Ministry staff members are permitted to teach in the EM program, they must undergo the same Training of Trainers preparation currently being administered to FM's Thal medical staff. This stipulation was generally accepted by Dr. Fatemi, Director of the Ministry's Training Institute; however, the Ministry is still in the process of determining what level of involvement it desires its representatives to have in the didactic phase of the advanced training program.

p. 61, paragraph 1, lines 6-12: The report discussed the effect that integrating instructors who are unfamiliar with "the FM expatriate teaching style" (presumably this refers to the competency-based aspect of the model) would have on the cost and viability of the advanced training program, as well as on the time frame within which the transition could be expected to occur.

Comment: The need for standardization of curricula has long been recognized-- indeed, the advanced program is based on WHO/ACBAR guidelines addressing this issue. Of equal if not greater importance is consistency and standardization in how individuals become qualified to conduct training programs. As the approach to the Afghan situation shifts from a crisis-orientation (the urgent need for healthcare providers in the rural areas has largely been met) to one of planning for development and maintenance of of a healthcare system, this issue will become increasingly important.

At present, Freedom Medicine is considering establishing a Training of Trainers program at the Thal facility. The TOT curriculum based on the competency-based training program is complete, and with minor revisions, this will serve as the foundation for FM's TOT program. The Thal site is an ideal location, as it is comprised of a training facility which includes living quarters as well as clinical operations comparable to those found in Afghanistan. Further, because the

advanced training program will be conducted there, it will be possible to incorporate a student-teaching element into the TOT program. While conducting a TOT program at Thal would require additional expatriate staff (until such time as the competency of Afghan TOT training staff could be assured), the program would facilitate the transition of the advanced training program and also provide a body of experienced Master-health trainers for the future.

p. 61, paragraph 2, lines 1--3: The report raised the question of future funding for health workers currently supported by the private and volunteer community.

Comment: The Swedish Committee for Afghanistan recently responded to an inquiry by the Ministry of Health in which all PVOs were asked general informational questions regarding their activities on behalf of the Afghan people. In addition to completing the questionnaire, the Swedish Committee expressed its willingness to support the Ministry's and the Interim Government's present and future efforts in Afghanistan.

p. 61, paragraph 3: The report suggested that the time frame for the transition be expanded to insure the quality of the final product and that the process be completed in an orderly and efficient manner.

Comment: Freedom Medicine concurs with the evaluators that more time will allow for a better product. However, it is also important to realize that since some of the problems with the curriculum can only be resolved within the context of an actual training program, the start date should not be delayed for an inordinate period of time. Further, one of Freedom Medicine's mandates from USAID for FY90 is that fifty (50) health workers be graduated from the advanced program by June 30, 1990.

In an effort to balance the competing demands of producing graduates in a timely fashion and insuring that the curriculum and transition are completed according to schedule, Freedom Medicine proposes to admit sixteen (16) students to the initial class and to delay the second class until the first one has been underway for two to three months.

p. 62, paragraph 3: The report mentioned the Ministry's proposed one-year training program for basic health workers and questioned how the its manpower resources would be distributed between that course and the Freedom Medicine three-month advanced program.

Comment: The issue of who will teach Freedom Medicine's advanced course was discussed on the preceding page.

The appropriateness of the Ministry's proposed one-year program for basic health workers is questionable; this was borne out by the evaluation team's own research, which indicated that an inordinately large number of low to middle level health workers are presently deployed in Afghanistan. Given this fact, a focus on retraining and upgrading the skills of those currently in the field is the most efficient course of action; indeed, Freedom Medicine's recruiting efforts have been directed at individuals who have already established their credibility with their commanders and community leaders.

It is Freedom Medicine's position that the Ministry should be encouraged that an ideal avenue through which it can establish credibility is through the development and implementation of a training program which is responsive to known needs and realistic in its approach and objectives.

p. 63, paragraph 4: The report offered several recommendations for Freedom Medicine's program.

Comments:

1. Dr. Karim, the Training Coordinator in Thal, has been added to the Freedom Medicine Transition Team.
2. As was stated above, if the start of the advanced program is delayed, it is unlikely that the mandate of training fifty (50) advanced graduates will be accomplished during FY90.
3. Again, conducting only one class during the first three month period will limit Freedom Medicine's ability to produce the requisite number of graduates in a timely fashion.
4. Sections on dermatology and pediatrics have been incorporated into the advanced curriculum. One of Dr. Fatemi's appointees is a specialist in dermatology; in addition, the pediatrician from Freedom Medicine's Chitral clinic site is developing the section on child health.
5. See response on page 4.

In closing, I must reiterate that Freedom Medicine welcomes the critique of the evaluation team and found the team's remarks to be insightful and appropriate. The foregoing is offered in the same spirit of cooperation, in the hopes that a better future for Afghanistan will result.

As always, please do not hesitate to contact me if you require further information.

Sincerely,



Robert H. Brenner
Project Director

December 13, 1989

FROM: Todd Petersen, IMC
SUBJ: Comments on Evaluation Report
TO: T. Eighmy
Thru: Doug Palmer

Generally, I think the report is quite good. However I believe there are some problems with it due to the short time frame the evaluation team had. Next evaluation team should be given clearer scope of work and more time.

Section on I.M.C. seemed to be something of an afterthought and quickly written. Many mistakes - examples: "three W.H.O. funded proposals including physician retraining"; only two W.H.O. funded proposals. Physician retraining funded by Donner Foundation. Much more than 40% of course is practical. I believe John got figures confused: 60% practical, 40% theory, not other way around. Very little was mentioned on our focus of strengthening existing clinics, expanding into underserved areas, present retraining. Since spring 89, I.M.C. has been retraining early medics routinely.

I don't believe the report gave PVO's enough credit concerning program sustainability and expansion in underserved areas. This is happening in 1989.

I strongly disagree with evaluation team recommendation on no new training, nor their assumptions that most areas have care. I could line up 10 Afghans from different parts of the North/West that will tell you nothing is there. John is totally wrong in this. He listened too much to Sharon McDonnell. The issue is distribution. Keep training but much smaller numbers and only in certain areas.

I will be very curious to see what impact (if any) this report has on MSH activities. John's comments on too many workers, no more support of basic health training, and medics trained under 6 months being dangerous seems to address MSH specifically. Yet in this time of budget cutbacks and tightening \$ as Doug indicated, I doubt MSH will shoulder any cuts.

I think it is a good report for the most part. It's only good however, in terms of what AID chooses to do with it!!

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MEMORANDUM

13 December 1989

TO: Doug Palmer

FROM: Dick Johnson *Dick*

SUBJECT: Evaluation Report - PVO Co-Financing & Rural Assistance Projects
Health Section - 30 Nov 89

As I have not had sufficient time to carefully review the above referenced report, I will try to make a few general comments.

It seem that the report does not take into consideration the fact that the MOPH has been running a refresher training program for doctors for over 1 year and a BHW refresher training. Also it would be useful to mention that one of the objectives of the Training Center now renamed the Institute of Public Health is to carry out testing and certification of BHWs and doctors and nurses attending refresher training. The MOPH is very definitely interested in standardization and it seems that PVO should be encouraged to work closer with the MOPH for this.

It is implied that an over abundance of health workers have been trained and there is not a need for more that retraining should be the objective to improve quality. Improving the quality is worthy however with regard to number of workers it really depends upon the health care delivery model. What are the health manpower requirement? There may be excesses in some categories and nil or shortages in other categories.

There are some statements made that seem based on opinion. For example page that graduates of midlevel programs unlikely to prescribe dangerous drugs while BHWs were "too often observed" following this practice. What is the source for such sweeping statements. Another opinion stated is something like the MOPH has no respect and is unable to implement projects. Such statements are based on what? *J*

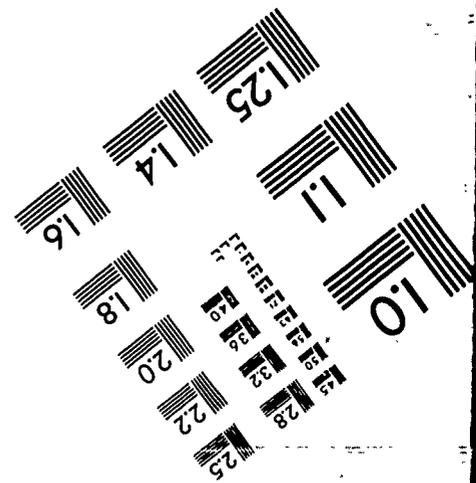
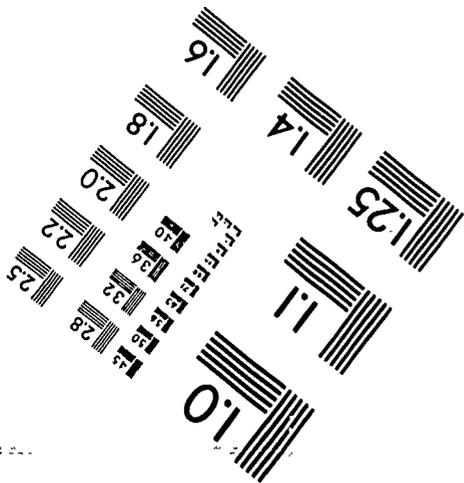
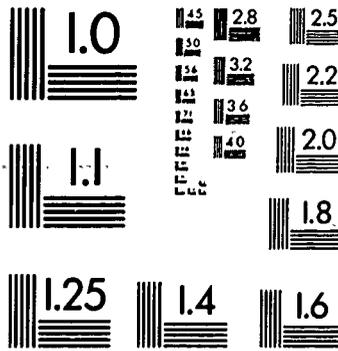
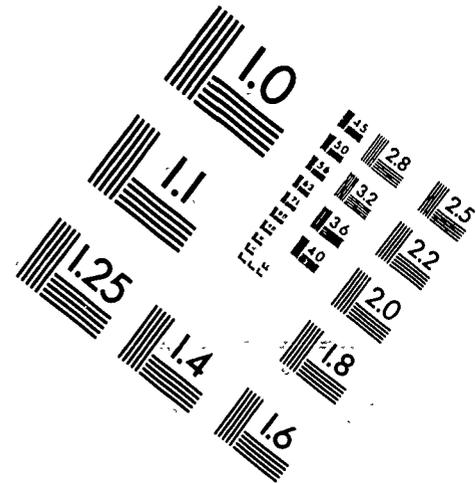
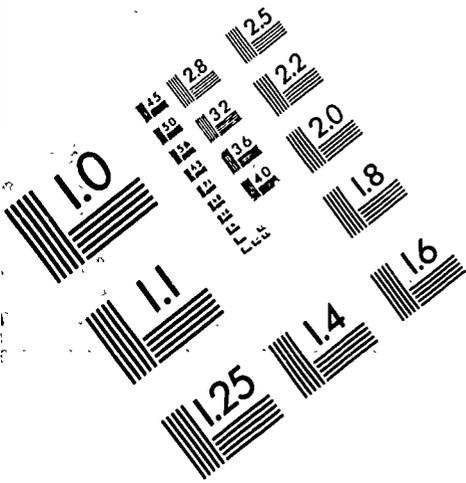
Frequently time or length of training is listed as the main factor indicating the level of health care worker. Time or length of training is certainly an important factor but it is really the training objectives that count. I do not believe that you can for example in the case of Freedom Medicine add a few (3) months to their primary or basic training and come up with an advanced medical technician. Specifically what will these "advanced workers be responsible for? Where will they fit in a model? Workers need to be judged against the training objectives rather than how much time passed since entering training.

- skill level

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The report would be more balanced if the role of the Village Health Worker or Basic Health Worker and his or her relationship with mid-level workers in a health care delivery system was described rather than simply saying this level (BHW) is dangerous. Actually I am trying to say we need to develop a model with definitions of where various levels of health workers fit and then decide what additional training or refresher or advanced or new training is needed.

I am not at all satisfied with these comments, as they were prepared in haste. Anyway for what ever they are worth. Let me know if you would like me to revise these comments and spend more time.



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