

PD-ABI-183



**MEDICAL HELP PROJECT FOR SOUTHWEST
AFGHANISTAN**

MERCY CORPS INTERNATIONAL

QUETTA, PAKISTAN

FINAL REPORT

1986-1993

**MEDICAL HELP PROJECT FOR SOUTHWEST
AFGHANISTAN**

(306-0211-A-00-1214) 1986-1991

Cooperative Agreement (306-0201-G-00-6005) 1991-1993

FINAL REPORT

JULY 1986 TO 31 DECEMBER 1993

**MERCY CORPS INTERNATIONAL
HOUSE #10 ARBAB KARAM KHAN ROAD
QUETTA, PAKISTAN**

**TELEPHONE: 81-440960
FAX: 81-443019**

**DR. IMAM, HEALTH DIVISION HEAD
DONALD BRADFORD, COUNTRY DIRECTOR**

ACKNOWLEDGEMENTS

We would like to acknowledge the many contributions of the dedicated and loyal staff of MCI to the successful accomplishment of this project. The support of MCI's programs by the Government of Pakistan and the Provincial Government of Balochistan is also gratefully acknowledged. The helpful guidance in implementing this program provided over the past few years by Mr. Douglas Palmer, United States Agency for International Development Health Projects Officer, is recognized with appreciation, as are the contributions of Mella Leiter, both in MCI's early days, and throughout the project. The assistance of Jamiat al-Ulama in MCI's early days is also recalled with gratitude. Most of all, we express our thankfulness to the people of Afghanistan, who - in the midst of hardship, displacement, destruction, and death - welcomed MCI and made it possible to implement this Medical Help Project.

Donald Bradford
Country Director

This report was prepared by Dr. Imam and Dr. Laurie C. Miller, Quetta, Pakistan, 1994. We apologize for any errors or omissions.

ANNEXES

ANNEX 1-Specific objectives from USAID for MCI Medical Help Project

ANNEX 2-Overview of MCI Medical Help Project activities

ANNEX 3-MCI Educational Philosophy

ANNEX 4-Chronology of medical worker training program and staff development activities 1986-1993

ANNEX 5-Outline of course curricula

- A. Basic health worker (First aid worker)
- B. Transitional public health worker
- C. Mid-level health worker (Advanced medical assistant)
- D. Mid-level health worker refresher course (Combined mid-level continuing education program [CMCEP])
- E. Maternal Child Health Assistant
- F. Out-reach worker

ANNEX 6-MCI Rules and Regulations for Students in Training

ANNEX 7-Geographic Distribution of MCI-administered health centers

ANNEX 7A-Active MCI Clinics per Province per year

ANNEX 7B-Maps

ANNEX 7C-MCI Clinics Level Breakdown per year

ANNEX 8-Reports of MCI-administered health centers in Afghanistan

ANNEX 9-Clinical activities of health facilities in Afghanistan

ANNEX 10-Patients seen at clinical facilities in Afghanistan

ANNEX 11-Calendar of physician monitoring of Afghanistan clinic operations

ANNEX 12-Calendar of physician debriefing of Afghanistan clinic staff

ANNEX 13-Chronology of medical activities inside Afghanistan and supporting warehouse and supply activities 1986-1993

ANNEX 14-Organizational charts

ANNEX 15-Chronology of administrative activities and expatriate support 1986-1993

ANNEX 16-Expatriate staff 1986-1993

ANNEX 17-Chronology of MCH activities 1986-1993

- 2

ANNEX 18-List of documents produced

ANNEX 19-Summary of major political events during the term of the project

ANNEX 20-Critical review of the project successes and failures

ANNEX 21-List of abbreviations

INTRODUCTION

Since 1979, Mercy Corps International (MCI) has designed, supported and implemented self-help development programs and provided emergency relief throughout the world. MCI is a non-profit, voluntary agency which strives to promote self-reliance, productivity and human dignity. MCI is registered with USAID (U.S. State Department's Agency for International Development) and is a member of InterAction. MCI receives support from private donors (6%), government grants (19%), and other grants (6%), but over 68% comes in the form of material aid from partner organizations.

MCI has been working in Afghanistan since July 1986, based in offices located in Quetta, Pakistan. MCI's operations have two major components: health and agriculture. At the peak of operation, these programs combined employed more than 580 individuals (about 460 in health and 120 in agriculture). More than 480 employees were based in Afghanistan. The programs developed as a humanitarian response to the war in Afghanistan, and have been conducted in cooperation with the people of Afghanistan. Initial programs focused on emergency medical needs; these then expanded to meet community health and other development needs of Afghan refugees in Quetta and the people of southwestern Afghanistan.

The health program had two major elements: health training and health services. Both components were originally designed to meet the emergency medical needs of people affected by years of war and the associated breakdown of governmental health services. This assistance reached a peak in 1991 with the support of 41 clinics and small hospitals in eight provinces: Kandahar, Urozgan, Helmand, Zabul, Nimroz, Farah, Ghor, Ghazni. Activities in a ninth province, Badghis, were discontinued in 1988. In support of these facilities in Afghanistan, MCI operated a number of training programs, a training and referral hospital, an outpatient department (OPD), and a maternal child health center (MCH) in Quetta.

These activities were conducted with the support provided by USAID under the terms of the Medical Help Project for Southwest Afghanistan (306-0211-A-00-1214) during the years 1986-1991, and Cooperative Agreement 306-0201-G-00-6005 from 1991-1993 (see Annex 1). Under the terms of these agreements, MCI, in collaboration with O/AID/REP, developed programs to improve the health system inside Afghanistan. A series of health posts, clinics and small hospitals were to be established throughout the south and southwest of Afghanistan to provide health care services. In addition, staff at these MCI-administered centers

4

were to be upgraded through basic and refresher training. Finally, these goals were to be met while reducing recurrent costs, in the hope that this would make the health system affordable to a future Afghan government and possible future donors. In order to accomplish these goals, MCI:

- *developed training staff, clinical facilities for practical training, and curricula for 5 distinct training programs

- *trained over 800 health care workers using these programs and supervised their field performance

- *established, maintained, supplied and monitored 39 clinics and small hospitals in SW Afghanistan

And, to support these programs, MCI

- *established a management structure for health programs

- *implemented a program of logistical operations

- *created a Management Information Systems center

Each of these components will be discussed below (see Annex 2 for overview). The period of these agreements was from July 1, 1986 until December 31, 1993.

5

HIGHLIGHTS OF MEDICAL HELP PROJECT

July 1, 1986: Medical Help Project signed by USAID and MCI

1986

- *Administrative unit developed in Quetta
- *First 3 month first aid course concluded
- *Five fixed clinics and 6 mobile units established in Afghanistan

1987

First quarter

- *Established a Board of Directors with representatives from seven political parties and local medical facilities to serve in advisory capacity to MCI
- *First expatriate medical worker arrives
- *After extensive review, relationship with Ansari Hospital is terminated
- *Curriculum committee is established to oversee organization of courses
- *Fact-finding mission conducted Dec 18 - Feb 22 by Engineer Ayubi and Mr. Faroug to assess medical needs in Kandahar, Rozgan, Helmand, Ghorat, and Herat. Determined locations of ~36 health facilities to be operated by MCI

Second quarter

- *Graduation of first Advanced Medical Assistant Course (6 month course)
- *Located site and developed plans to establish Al-Jehad Training Hospital
- *Developed broad educational objectives for training programs and established guidelines for student participation in MCI training

Third quarter

- *Renovated space at Al-Jehad Hospital to prepare for opening
- *Developed personnel policies for employees of Al-Jehad Hospital
- *Developed organizational structure for Al-Jehad Hospital

Fourth quarter

- *Created position of Health Training Coordinator
- *Improved methods of selecting students for MCI training courses

1988

First quarter

- *Established a Maternal-Child Health room as part of Al-Jehad Outpatient Department
- *Afghan physician hired as first training doctor

- *Curriculum development coordinator hired
- *Developed an improved plan for conducting monitoring of health facilities inside Afghanistan

Second quarter

- *Established 3 new surgical clinics and 6 more OPD units inside Afghanistan
- *Successfully supplied 5 surgical clinics, 14 OPD units, 10 mobile units, and 200 first aid workers
- *Upgraded Al-Jehad to a surgical training facility

Third quarter

- *Restructured AMA course to include 3 months of general training and 3 months of specialty training
- *Initiated process of debriefing clinic workers (extensive 3-4 hour interviews regarding diagnoses, treatments and clinic operations) when returned for resupply

Fourth quarter

- *Established Medical Review Board to oversee medical practices at Al-Jehad Hospital
- *As fighting intensity in Afghanistan decreased, reordered the focus of the 3 month First Aid Course from emergency treatment of the wounded to a broader "Basic Health Worker" Course

1989

First quarter

- *Renewed Medical Help Project Agreement between USAID and MCI for 1989-90 project year
- *Executive Committee formed of key Afghan and expatriate staff to review MCI general administrative operations
- *Students began to see female patients during OPD rotations

Third quarter

- *Trained two technical monitors to work full-time in Afghanistan
- *Completed the "Common Disease Manual and Formulary" for the AMA course
- *Expanded length of training courses to include more practical experience: AMA course now 8 months duration, BHW course 14 weeks duration

Fourth quarter

- *First Outreach Workers graduated

1990

First quarter

- *MCI students began training in manufacturing prostheses in cooperation with OHI
- *Computerized Al-Jehad ward paperwork

7

Second quarter

- *Expanded debriefing activities to include dental and laboratory workers
- *Upgraded and computerized warehouse inventory system

Third quarter

- *Signed Memorandum of Understanding with Jamiat al-Ulama regarding management of Al-Jehad Hospital
- *Expanded training staff to include all medical staff

Fourth quarter

- *Appointed four Afghans as department heads: Training Programs (Dr. Amanullah), Inside Afghanistan Clinic Operations (Dr. Imam), Warehouse and Supply (Mr. Aman), and Support Services (Haji Aminallah)

1991**First quarter**

- *Expatriate staff evacuated because of Gulf War
- *Instituted fee-for-service at many facilities
- *Reduced stipends for health workers inside Afghanistan 50%

Second quarter

- *Signed Cooperative Agreement with USAID for 1991-92 project year
- *Developed 3 month MCH assistant training curriculum; started first course
- *Established separate training division, distinct from "inside" activities
- *Completed one year of sole management of Al-Jehad Hospital
- *Established separate facility for MCH Clinic - the only MCH Clinic in Quetta for Afghan refugees
- *Established fee-for-service for MCH and surgical services

Third quarter

- *USAID suspended all support for medical services inside Afghanistan
- *Began first Combined Mid-Level Continuing Education Program (CMCEP) refresher training
- *Appointed an Afghan woman physician the Head of MCH Clinic
- *Warehouse began to receive supplies as part of Combined Procurement Program

Fourth quarter

- *First CMCEP course concluded
- *Fee-for-service initiated for inpatient treatment and at MCH Clinic for non-essential labwork
- *Curfew for 11 days in Quetta

1992

First quarter

- *USAID lifted suspension of medical activities inside Afghanistan
- *Final AMA course (VII) concluded
- *6 surgical beds at Al-Jehad transferred to medical ward; contagious disease ward started
- *Broad outline of plan to move all training operations to Kandahar prepared

Second quarter

- *All surgical activities at Al-Jehad discontinued
- *Completed standardization of all salaries of health workers inside Afghanistan
- *Sent first of a series of training staff to Aga Khan Hospital in Karachi for observation and refresher training

Third quarter

- *Discontinued all benefits at clinics inside Afghanistan, including food, generator supplies, fuel, transport
- *Discontinued all local purchase of medical supplies, expanded use of combined procurement system
- *Female doctors included on morning rounds on hospitalized patients
- *Visited Kandahar to explore possibility of collaboration with Mirwais Hospital

Fourth quarter

- *Dr. Imam appointed Health Division Head
- *Al-Jehad closed December 10 in accordance with directive from USAID
- *MCH Clinic closed December 30 in accordance with directive from USAID
- *Developed and instituted extensive plans to rehabilitate and renovate Mirwais Hospital in Kandahar to serve as base of training operations
- *Established plans to utilize Common Kit System
- *Began phase-out of all but 21 health facilities operated inside Afghanistan in accordance with directive from USAID
- *Assembled Training Staff to work at Mirwais Hospital in Kandahar

1993

First quarter

- *Completed rehabilitation of Mirwais Hospital
- *Completed phase-out of redundant clinics inside Afghanistan in accordance with directive from USAID

Second quarter

- *Mirwais Hospital significantly damaged in renewed fighting in Kandahar

*Notified by USAID of discontinuation of all funds for medical programs; prepared final phase-out plans

Third quarter

*Concluded CMCEP IV course in Boldak

Fourth quarter

*Terminated all USAID-funded medical activities in Pakistan and Afghanistan

I. HEALTH WORKERS TRAINING PROGRAM: OVERVIEW

INTRODUCTION

The entire health care system in SW Afghanistan was destroyed during the war of resistance of the Soviet invasion. At the beginning of MCI's involvement in the region, health care professionals were urgently needed to assist the people of Afghanistan living under conditions of war. The main goal of MCI's medical training program was to train qualified health workers to provide health care services in rural areas of Southwest Afghanistan (see Annex 3).

In July 1986 MCI's Medical Training Program began with a three month course to train first-aid workers. This was supplemented with a 6 month training course for advanced medical assistants (AMA): the first of these courses began in October 1986 with 40 students. Eventually, MCI's Medical Training Program developed and conducted training courses for: Mid-level Workers, Basic Health Workers, Out-reach Workers (Malaria & Tuberculosis Educators), Mother and Child Health Care Assistants, and Refresher/Retraining course for mid-level health workers. With non-USAID assistance, MCI also provided training for Traditional Birth Attendants and vaccinators. All programs were designed to train qualified health workers to work in areas of need in the shortest possible period of time. Proper diagnosis and treatment of the most urgent health problems of the Afghan population was emphasized.

The graduates of these courses were able to provide first aid assistance, correct diagnosis and treatment of common diseases, basic nursing, and health education. The curricula of MCI's training courses were adapted to the changing needs and requirements of the communities served, as well as the changes dictated by the war situation. In this section, an overview of the health worker training programs will be given, followed by a description of each training course.

OBJECTIVES

1. To establish appropriate clinical facilities to serve as a base for practical training and as a referral hospital for clinics inside Afghanistan

2. To develop a capable, flexible training staff with expertise in clinical practice as well as teaching
3. To select students with the intellectual abilities to succeed in the course work, and the personal committment to carry out medical work in SW Afghanistan under the supervision of MCI
4. To produce curricula for the training courses that were concise, comprehensive, and relevant to the existing situation
5. To institute a fair and effective system to evaluate students
6. To promote ongoing staff development activities

ACCOMPLISHMENTS

Establish appropriate clinical facilities to serve as a base for practical training and as a referral hospital for clinics inside Afghanistan

In order to train health care workers, clinical facilities were required (see Annex 4). In Quetta, Al-Jehad Hospital had been established in 1983 by Jamiat-al-ulama to care for the Afghan war-wounded. In addition to an active surgical service, Al-Jehad also had a large, busy male OPD. Rather than creating a completely new clinical facility, MCI began a cooperative arrangement with Al-Jehad in 1986 to use the facility for practical training of its students. Because of the requirements of training, many hospital departments were expanded and new personnel were hired, including expatriate hospital and nursing coordinators. Expatriate advisors were recruited in many departments, including x-ray, laboratory, dental, and medical and surgical nursing, to supervise students and assist with training.

An inpatient medical ward and a female medical ward were established in 1991. The maternal child health clinic (MCH) was established as one room in the OPD, then expanded to a full separate clinical facility in 1990. Over time, clinical activities not directly in support of training were gradually phased out.

Develop a capable, flexible training staff with expertise in clinical practice as well as teaching

An expatriate Coordinator of Training Programs at MCI selected the training doctors, and supervised the day-to-day activities of all of the training courses. The Training Staff began with a single doctor who gave lectures to the students. The students then worked at Al-Jehad Hospital for practical training under the supervision of staff physicians. As the training program intensified, 2 additional training doctors were hired to assist with lectures. By 1989, 5 training doctors were

working full-time in the mid-level training program, 3 half-time doctors in the BHW training program, and 1 doctor in the Outreach Worker training course. In 1991, an additional doctor was added to the training staff. The doctors selected for training had experience in a wide range of medical specialities, including general surgery, otolaryngology, pediatrics, gynecology and obstetrics, psychiatry, radiology, infectious diseases.

The training staff held weekly meetings to review the work of the previous week and to plan the work of the coming week for each course. The doctors divided their time between giving lectures, demonstrations, and supervising the students during practical experience.

Select students with the intellectual abilities to succeed in the course work, and the personal committment to carry out medical work in SW Afghanistan under the supervision of MCI

All training was conducted with the intention of providing support to health care facilities inside Afghanistan. In consultation with various political factions controlling SW Afghanistan, MCI determined locations where there was a need for a health clinic, where security could be maintained, and where the activities of the clinic would be accepted by the local population. Prior to the selection of students a steering committee was established in Quetta. This committee was composed of key commanders from all seven Islamic political parties involved in the resistance against the communist regime in Southwest Afghanistan. The committee identified suitable locations for health facilities in the 9 provinces of southwest Afghanistan. The commander in-charge of each identified district then selected several candidate-students for each course.

These candidate-students came to Quetta for screening entrance examinations to evaluate their basic knowledge. The screening examinations were prepared by the training staff. Only about 1/3 of candidates were selected. Students were thus chosen in part on geographic basis to ensure distribution of workers throughout SW Afghanistan, but also based on the results of screening tests to insure that all students selected had sufficient basic knowledge necessary to succeed in the training course.

Produce curricula for the training courses that were concise, comprehensive, and relevant to the existing situation

Considerable effort on the part of MCI's Training Staff was required to develop focused, relevant, and manageable training courses. Five distinct courses were developed. The Training Staff worked together to agree upon the academic topics to be included, the teaching methodologies to be used, and the proper allocatation of the students' time to different subjects.

13

Training material was translated into Dari and/or Pushto, printed, and distributed to each student.

During the span of this project, the Training staff continually reviewed the content of the offered courses to ensure relevance of material to the changing situations that the students would face inside Afghanistan. This was done during weekly staff meetings as well as during more formal course review sessions. For example, during periods of heavy bombardment, more emphasis was given to management of war injuries; during periods of malaria outbreaks, diagnosis and treatment of this disease was emphasized.

A brief description of each course follows; further details of each course are outlined in Section II Health Workers Training Program: Description and Annex 5.

A. Basic Health Worker (BHW) Training Course. This 3 month course emphasized first aid, nursing skills, and the diagnosis, treatment, and prevention of 21 basic diseases. This course was developed by MCI Training Staff, and was later expanded for use in the mid-level course. The course covered basic first aid of injuries, shock, burns, fractures, bleeding control, and poisoning (insect bites, chemical warfare), and gave practical experience in wound care, immobilization techniques, and patient transport.

B. Advanced Medical Assistant (AMA) Training Course. The MCI training staff developed this 6 month curriculum, based in part on the Peshawar Coordinating Medical Committees program (for the section on Common Illnesses). This Committee developed a Common Diseases Training Manual. MCI also developed a Formulary, a First Aid Training Manual, and Nursing and Mathematics Skills Manuals. All Manuals were prepared in English, Pushto, and Dari. Training Materials from Medex Primary Health Care Series (University of Hawaii, 1833 Kalakaua Ave., #700, Honolulu, HI) were also adapted for local use. Three months of each course were devoted to specialty work in outpatient medicine, x-ray, dentistry, nursing, surgery, or laboratory work. Students were selected for each speciality course based on the needs in their home districts. The 6 month AMA course was later expanded to a full 12 month "Mid-level Health Worker" training program.

C. Combined Midlevel Continuing Education Program (CMCEP) Training Course. This 18 week refresher course was developed by the combined efforts of MCI, IMC, MSH, Swedish Committee, WHO, and MOPH. Initially, representatives from each organization met monthly. Then, to expedite preparation of the course, a Core Group was formed including a representative from each organization. This Core Group worked intensively for 4 months to finalize a working curriculum. When this curriculum was completed, the mid-level refresher course was begun. After each

course was completed, the Core Group met to review the contents of the curriculum, and appropriate up-dating and revisions were done. Continued review of the curriculum, performance of the students, and other related matters continued throughout the time the courses were offered.

D. Maternal Child Health (MCH) Assistant Training Course. This course was adapted from the mid-level training course, with special emphasis on pregnancy, obstetrics, and child health. Practical training was conducted at MCI's MCH Clinic as well as the gynecology and obstetric facilities at Shuhada Clinic in Quetta.

E. Outreach Worker Training. This course was similar to the BHW course but had a special emphasis on community health issues. Students were instructed in appropriate community followup of specific diseases such as tuberculosis and malaria. The course also included training in basic first aid, nursing skills, and community health education. For practical experience, the students worked in the clinic under supervision, but also practiced community-based followup.

Institute a fair and effective system to evaluate and supervise students

Students all lived in a dormitory established and maintained by MCI. The dormitory was closely supervised by the Training Staff and the Director of Afghanistan Clinic Operations. Very strict rules and regulations were maintained (see Annex 6). Few difficulties were encountered with the students: attrition due to misbehavior was very rare throughout all the training courses.

Academic performance of all students was also strictly monitored. Examinations (written, oral, and practical) were given frequently in each course. Students received immediate reports of their performance, and tutorial assistance was given when needed. Weak students received extra attention and tutoring. Additional examinations were administered to ensure mastery of the academic material. If unable to perform adequately, students were asked to withdraw from the training course. This happened rarely.

Informal monitoring of courses was done by USAID and by The Coordination of Medical Committees at intervals.

In addition to close supervision during the time of training, the performance of mid-level and basic health workers was also monitored after graduation. Details of the monitoring operations are described below [see Section III Afghanistan Health Centers].

Promote ongoing staff development activities

In addition to an ongoing review of student performance, the performance of the Training Staff performance was also monitored by the supervisory staff. Teaching abilities, including conduct of lectures and practical demonstrations, were all observed by supervisors. The pedagogical skills of many members of the training staff were upgraded by participation in several Training of Trainers Workshops (in Peshawar and Quetta).

A training program to upgrade the skills of the training nurses at Al-Jehad hospital was also established. The Training Staff Doctors and expatriate advisors offered a lecture series once per week for 2 hrs. In addition, 8 of the Training Nurses and Doctors (including some members of the MCH staff) were sent to Aga Khan Hospital in Karachi to observe, to upgrade their skills, and to participate in clinical activities. Finally, the Outreach Worker Training Doctor was sent to a Training of Trainers (TOT) course in Peshawar.

II. HEALTH WORKERS TRAINING PROGRAMS: DESCRIPTION

A. BASIC HEALTH WORKERS TRAINING PROGRAM (First aid training course)

INTRODUCTION

The Basic Health Workers (BHW) or First Aid training course was initially designed to recruit and train health workers from amongst the mujahadeen and resistance to assist the war-injured. Between 1986-1990, this course was conducted in cooperation with an Afghan NGO. Then, as MCI took full responsibility of this training course, the focus evolved to include more training in skills needed to care for the basic health care problems of the general population. Because of the increased emphasis on these topics, the final two BHW courses offered were titled "Transitional Public Health Worker" (TPHW) courses. The training course was designed to foster the students' abilities to work independently in the field, to provide basic first aid to war-wounded, to assist ill citizens, and to encourage basic preventive health care measures.

OBJECTIVES

1. To provide students with sufficient skills to perform life-saving first aid measures, including:
 - a. Hemostasis
 - b. Treatment of shock, cardiac arrest, and choking
 - c. Safe transport of injured patients
 - d. Management of basic emergencies
2. To develop a curriculum which provides a background in basic health problems and public health, including:
 - a. Common diseases and prevention
 - b. Water and sanitation
3. To train students in basic methods of community health education
4. To improve the health status of the population of SW Afghanistan

ACCOMPLISHMENTS

Provide students with sufficient skills to perform life-saving first aid measures

Between 1986 and 1990, nearly 300 BHWs were trained and sent to work inside Afghanistan. These trained BHW went to the front lines of war with the mujahadeen. It was not possible to measure the performance of the BHWs directly. However, from countless reports, their contributions were felt to be extremely valuable, and their presence also had a positive impact on the morale of mujahadeen.

Develop a course curriculum which provides a background in basic health problems and public health

The course curriculum included sections on basic anatomy and physiology, first aid, basic nursing skills, 21 common diseases, and fundamentals of public health and health education.

Improve the health status of the population of SW Afghanistan

Undoubtably, ~200 trained, supervised active BHWs in SW Afghanistan improved the health status of the population, but again this was impossible to measure directly. During their training, it was emphasized to the BHW students that when they returned to Afghanistan, their skills were to be made available to all, including women and children. Ongoing field support and debriefing of MCI-trained BHWs ensured basic quality of care (see Section III Afghanistan Health Centers).

Table 1
Basic Health Worker Training Courses
1986 to 1990

Course #	Dates	# of students (start/graduate)	# working inside(%)
1	07/07/86-10/21/86	40/28	16 (57%)
2	10/07/86-01/03/87	52/26	21 (81%)
3	01/10/87-04/30/87	42/29	22 (76%)
4	05/04/87-08/05/87	39/26	21 (81%)
5	08/28/87-11/30/87	36/26	16 (62%)
6	12/15/87-03/22/88	47/24	15 (63%)

7	04/02/88-06/18/88	22/22	15 (68%)
8	07/30/88-10/18/88	26/18	15 (83%)
9	01/02/89-03/16/89	18/14	13 (93%)
10	04/01/89-07/06/89	26/19	15 (78%)
11	08/19/89-11/23/89	25/24	12 (50%)
TPHW#1	12/23/89-02/28/90	30/22	9 (41%)
TPHW#2	04/08/90-07/17/90	21/17	N/A
TOTAL		426/295	190+ (68%)

B. MID-LEVEL HEALTH WORKERS TRAINING PROGRAM (ADVANCED MEDICAL ASSISTANT)

INTRODUCTION

The mid-level health worker is the backbone of the health care delivery system in Afghanistan. In remote areas, the mid-level health worker may be the only health care provider for the population. In other regions, they provide the bulk of health care. Mid-level health workers must have the ability to function independently and safely without direct supervision.

OBJECTIVES

1. To train mid-level health workers, with the abilities to deliver Primary Health Care (PHC), Nursing skills and First aid services safely, adequately and properly according to World Health Organization mid-level standards and guidelines. The PHC services include:
 - a. Health education
 - b. Nutrition
 - c. Immunization
 - d. Maternal - Child Health
 - e. Water and sanitation
 - f. Control of endemic diseases
 - g. Treatment of common diseases
 - h. Provision of essential drugs

2. To reduce the overall morbidity and mortality rates in Afghanistan.
3. To establish a training hospital in Quetta for use as a practical field hospital as well as a referral hospital for clinics inside Afghanistan.
4. To establish a course curriculum for the Midlevel health worker training program.
5. To staff MCI health facilities inside Afghanistan with qualified health workers.

ACCOMPLISHMENTS

Train mid-level health workers (Advanced Medical Assistants)

The first class of mid-level health workers (advanced medical assistants) training began in October 1986 with 40 students enrolled. Students were selected from amongst experienced first aid workers. Between October 1986 and January 1992, MCI conducted seven mid-level training courses; five were 6 month courses (151 students) and two were 12 month courses (56 students). A total of 207 mid-level health workers were trained under this program. As described above, each course consisted of both Basic and Specialty training. Among the graduates of the program, 114 were trained in outpatient medicine, 41 in dentistry, 35 in laboratory work, 8 in inpatient nursing, 5 in x-ray, and 4 in surgical nursing.

In 1991, MCI conducted the final mid-level health worker training program (January 6, 1991 to January 9, 1992). These trained medical personnel now comprise the backbone of SW Afghanistan's health care system.

Reduce the overall morbidity and mortality rates inside Afghanistan

The provision of 207 trained mid-level health workers had a significant impact on health services in Southwestern Afghanistan. The mid-level health workers were able to help the war-injured and mine victims, and save thousands of citizens from immediate death. More than 250,000 patients were served by the clinics staffed by MCI-trained health workers. Notably, women and children comprised 50% of the clinic patients.

Establish a training/referral hospital and clinic in Quetta

As briefly described above, MCI established a training hospital in Quetta (Al-Jehad Hospital), in cooperation with a local Afghan NGO, to be used as a training and referral facility. The hospital had the following units:

1. *Surgical ward:* 30 bed capacity, mainly serving war victims referred from Afghanistan based clinics. Comprehensive surgical services were available. Students were able to gain practical experience in pre-, post-, and peri-operative surgical nursing skills.

2. *Medical ward:* 15 bed capacity for internal medicine, with 5 beds allocated for female patients. Later, a contagious disease ward was added.

The occupancy rate for both wards was 90%.

3. *Out-patient Department:* Each day, 150-200 men and boys received comprehensive medical care.

4. *Mother and Child Health Care Center:* The MCH clinic began as a one room clinic in 1987 as a part of the male out-patient department. Over the next few years, the clinic expanded to a large, physically separate facility staffed by five Afghan female doctors and 10 nurses. The main services provided included pre- and post-natal care, diagnosis and therapeutic management of common diseases, immunizations, nutritional monitoring and provision of nutritional supplements to treat malnutrition, health education, and family planning. An average of 250 patients/day were served in this clinic.

The nutrition program served over 200 malnourished children and pregnant mothers per month. Although terms of this project did not permit investigation of the outcome of specific intervention, experience suggests that the nutrition program clearly improved childhood morbidity and mortality rates among the target population.

Establish a course curriculum for the mid-level training program

The Training Program is briefly described above. Training materials developed for this course are included in Annex 5.

Provide health workers to staff MCI-administered clinics

Graduates from the MCI mid-level training program were appointed to MCI-supported clinics and health posts in Afghanistan. Because students were selected from the districts where clinics were established, nearly all returned to these areas after graduation to work.

A program to monitor, debrief, and support students in the field continued on a regular basis. This allowed the Training Staff to evaluate the knowledge and practical abilities of these health workers, and to obtain valuable feedback information for ongoing training programs. (see Section III Afghanistan Health Centers).

Table 2
Advanced Medical Assistant (mid-level) training courses
1986 to 1993

Name of the course		Start	End date	# of students
1. Midlevel course	I	Oct 86	Apr 87	40
2. Midlevel course	II	Jul 87	Jan 88	29
3. " " "	III	Feb 88	Aug 88	26
4. " " "	IV	Oct 88	Apr 89	26
5. " " "	V	Jun 89	Jan 90	30
6. " " "	VI	Mar 90	Mar 91	28
7. " " "	VII	Jan 91	Jan 92	28
TOTAL GRADUATED				207

C. COMBINED MIDLEVEL CONTINUING EDUCATION PROGRAM (CMCEP)

INTRODUCTION

In December of 1990, O/AID/REP notified MCI and other USAID-funded agencies of the decision reached during review of Health Sector programs. According to this decision, training of new health workers was to be discontinued; funding for training new students would be withdrawn in September 1991. Rather, emphasis was to be placed on developing and conducting a refresher training program for mid-level health workers. To help promote standardization and increase the affordability of the Afghan health care system, it was recommended that support of mid-level health workers would be limited to those individuals working with organizations involved in a combined training program.

The organizations, International Medical Corps (IMC), Mercy

Corps International (MCI), Management Science for Health (MSH), Ministry of Public Health of Interim Government of Afghanistan (MOPH/IGA), and Medical Training for Afghans (MTA), were informed that continued USAID funding depended on a cooperative arrangement to develop and conduct a mutually acceptable plan for mid-level continuing education training.

Thus, the Combined Continuing Mid-Level Education Program Core Group was established, comprised of the above-listed agencies plus the World Health Organization (WHO) and Swedish Committee for Afghanistan (SCA). The Core Group developed a draft plan and curriculum for CMCEP training; the pilot courses began by MCI/Quetta and IMC/Tall on July 28, 1991.

OBJECTIVES

1. To develop a standardized Mid-level Continuing Education curriculum which could be incorporated appropriately into a future health care delivery system in Afghanistan.
2. To strengthen the mid-level health worker's practical skills and knowledge (according to WHO standards) about the delivery of Primary Health Care services including:
 - a. Health education
 - b. Nutrition
 - c. Immunization
 - d. Maternal - Child Health
 - e. Water and sanitation
 - f. Control of endemic diseases
 - g. Treatment of common diseases
 - h. Provision of essential drugs

ACCOMPLISHMENTS

Develop a standardized Mid-Level Continuing Education curriculum

The Combined Mid-level Continuing Education Program (CMCEP) curriculum was developed according to the guidelines and under the direct supervision of WHO. The majority of topics were taken from MCI's mid-level course manuals.

Strengthen the midlevel health worker's practical skills and knowledge (according to WHO standards) about the delivery of Primary Health Care services

The pilot CMCEP course (July 28, 1991 to November 6, 1991) was conducted by MCI in Quetta. There were 24 students enrolled in this course. The trainees were selected by the CMCEP Core Group in Peshawar. All of the candidates were actively working in Afghanistan, supported by different agencies such as the International Medical Corps (IMC), Management Science for Health (MSH), Swedish Committee for Afghanistan (SCA) and Ministry of Public Health of the Interim Government of Afghanistan (MOPH). After the pilot course, two complete refresher courses were conducted in 1992 in Quetta. By the end of 1992, it was planned to move the majority of MCI's operations to Kandahar, including the training program (by directive of USAID). MCI decided to restore a part of Mirwais Hospital in Kandahar, which was damaged by the war, to use as a base of training operations. The reconstruction began in February 1993; CMCEP Course IV commenced in Kandahar in June 1993, with 14 students enrolled. Unfortunately, the course was interrupted by two major battles in Kandahar. This final course completed on November 28, 1993 in Boldak; 13 students were successfully graduated.

Table 3
CMCEP training courses
1991 to 1993

Name of the course	Start	End date	# of students
1. CMCEP course I	Jul 91	Nov 91	24
2. " " II	Feb 92	Jun 92	20
3. " " III	Jul 92	Nov 92	19
4. " " IV	Jun 93	Oct 93	13
Total			76

D. MATERNAL CHILD HEALTH (MCH) ASSISTANTS TRAINING PROGRAM

INTRODUCTION

Mother and Child Health Care services were very limited in Southwest Afghanistan during the war years. The population had access to MCI health centers, but many women could not attend the clinics because of the traditions of purdah. These cultural traditions also affected the adequacy of care provided to small

children. The demand for female health workers was extremely high. Therefore, MCI designed a three month course in Quetta to train female health workers, utilizing MCI's MCH center as a training facility.

OBJECTIVES

1. To train women to assist mid-level health workers in existing clinics with tasks which are culturally inappropriate for men.
2. To train women to promote MCH activities in existing clinics.
3. To train women to promote health education activities for both women and children.
4. To train women to act as liaisons between the clinic and community-based female health workers (i.e., TBA and FCHW).

ACCOMPLISHMENTS

Train women to: assist mid-level health workers in existing clinics with tasks which are culturally inappropriate for men, to promote MCH activities in existing clinics, to promote Health education activities in with women and children, to act as liaisons between the clinic and community-based female health workers

A course curriculum was designed to accomplish the stated objectives, and translated into Pushto, Dari, and English. Students were recruited among the Afghan refugees living in Quetta, with the understanding of their willingness to return to their home villages in Afghanistan after graduation to work in MCI-administered clinics. The recruitment of women meeting these criteria, who had the necessary background to benefit from the training was difficult, as deeply entrenched cultural practices interfere with the education and freedom of movement of women. Nonetheless, able and willing students were recruited, and two courses were successfully conducted. Two women went to their posts in Afghanistan, but unfortunately could not be supported due to the USAID ban on all cross-border medical activities at that time. The other trainees could not be placed due to security concerns in the areas where it was planned for them to work.

Table 4
MCH Assistant's Training Courses
1991 to 1992

Name of the course	Start	End date	# of students
MCH assistant course I	Jun 91	Sep 91	7
MCH assistant course II	May 92	Aug 92	6
Total			13

E. OUT-REACH WORKER (ORW) TRAINING COURSE

INTRODUCTION

As the intensity of hostilities in SW Afghanistan lessened, it became apparent that primary health care and public health were in dire need of strengthening for the entire population. To respond to these needs, an Out-Reach Workers training program was developed. This course was designed to train village level health workers in basic out-reach techniques, with a main focus on Primary Health Care. It was hoped that such a system could form the foundation for the integration of a primary health care component into MCI's health facility system inside Afghanistan. It was envisioned that the trained ORWs would be attached to and supervised by MCI's medical facilities inside Afghanistan.

OBJECTIVES

1. To train ORW students with the ability to promote health and prevent disease by:
 - a. conducting community health education regarding prevention of disease, simple treatments (such as ORS solution for diarrhea and dehydration), hygiene, nutrition, sanitation and vaccination
 - b. case finding and follow-up of TB and Malaria in the community
 - c. knowledge of basic life-saving first aid measures
 - d. knowledge of basic nursing skills and techniques, such as wound care, dressings, sterilization techniques, and injections
 - e. ability to prepare specimen slides after proper collection of samples to diagnose cases of TB and Malaria

ACCOMPLISHMENTS

Train ORW students with the ability to promote health and prevent disease

A single out-reach worker training course was conducted in October 1989. MCI and AICF trainers taught the classes and supervised the practical experience. Fourteen students successfully completed the course, 7 for MCI's TB control facility in Baghran, Helmand, and 8 for Health Unlimited's facility in Daichopan, Zabul province.

SUMMARY OF ACHIEVEMENTS

To summarize, through MCI's direct involvement, a large number of medical personnel were trained for work in Afghanistan, including:

- A. 295 Basic Health Workers (BHW)
- B. 207 Mid-Level Health Workers (with specialty training in OPD, Dentistry, Laboratory, or Radiology)
- C. 13 MCH Assistants
- D. 14 Outreach (TB/Malaria Control) Workers
- E. 76 mid-level health workers with refresher training

Table 5
Summary of training courses
1986 to 1993

No	Course Name	Duration	# students	# working in MCI Clinic in Afghanistan
1	Midlevel I	Oct 86 -- Apr 87	40	32
2	Midlevel II	Jul 87 -- Jan 88	24	22
3	Midlevel III	Feb 88 -- Aug 88	22	20
4	Midlevel IV	Oct 88 -- Apr 89	26	26
5	Midlevel V	Jun 89 -- Jan 90	30	29
6	Midlevel VI	Mar 90 -- Mar 91	28	28
7	Midlevel VII	Jan 91 -- Jan 92	28	26
8	CMCEP Pilot	Jul 91 -- Nov 91	24	24
9	CMCEP II	Feb 92 -- Jun 92	20	20
10	CMCEP III	Jul 92 -- Nov 92	19	19
11	CMCEP IV	Jun 93 -- Oct 93	13	13
12	MCH Assistant I	Jun 91 -- Sep 91	7	3
13	MCH Assistant II	May 92 -- Aug 92	6	0
14	Out-Reach Worker	Oct 89 -- Jan 90	14	14
15	Basic Health Worker	Jul 86 -- Oct 90	295	190+

CHALLENGES AND CONSTRAINTS

Attrition of trained health workers and students

A serious problem for many organizations involved in training of health workers for Afghanistan was the loss of health workers after graduation. There were several reasons for this, including the enormous demand for health workers in refugee camps and other areas where refugees had settled. The trained workers, instead of returning to their villages in Afghanistan, thus often started private businesses in the camps or surrounding areas. To circumvent this problem, MCI chose students from the regions where clinics were operating, and established agreements with local authorities to increase the likelihood that selected students would return to these areas to work.

Another area of attrition occurred during the courses, when students were found to be unable to perform the necessary academic work. Early on, MCI discovered that some enrolled students were illiterate in their mother tongues, making their participation in the training courses very difficult. This problem was solved by introducing stringent screening examinations so that academic ability of each student was ascertained prior to enrollment.

Compliance of students with course requirements

In the first months of conducting training courses, some difficulties with the students were encountered; specifically related to dormitory regulations and specialty assignments. At one point, the students even called a "mini-strike" to air their complaints. A committee of students was formed to liaison with the Training Staff, so that grievances could be aired, and disputes settled. As time progressed, a clear statement of objectives and expectations on the part of MCI staff at the start of each course served to minimize student dissatisfaction, and to improve compliance of students with specialty assignments.

Difficulties overcoming the cultural biases against education and freedom of movement of women

Although aware of the cultural practices which limited the options for women in terms of education and freedom of movement, the depth and extent of these practices were somewhat unexpected. Initially, MCI attempted to establish a TBA training program, drawing candidates from female residents of Kandahar. Although not the only difficulty in establishing this program, the unwillingness/inability of designated candidates to travel to Quetta for training was a major reason for the failure of this

initiative. Likewise, when MCI finally did succeed in training 13 MCH assistants, security constraints and the USAID-required ban on medical activities in Afghanistan prevented their placement or support. The timing of this ban was particularly unfortunate in terms of successful establishment of these workers in Afghanistan.

Need for standardization of courses

Although MCI began a course for female mid-level workers, this course was stopped by USAID because it had not been standardized. Although the need for female health workers was extreme, the requirement for a standardized course greatly hindered the training. Circumstances did not permit the work required to create a standardized course, thus all the preliminary work of recruiting and preparing to train female mid-level workers was lost.

Relationships with military commanders

Extensive amounts of time was required to inform the powerful military commanders from SW Afghanistan about MCI's programs, and persuade them to allow these programs to operate in their districts. First, the commanders had to be convinced of the need for the programs in their districts, then their support had to be enlisted. Unavoidably, disputes arose between MCI and the commanders over staffing levels, available equipment, salary support, and other issues. It required a major time commitment from some of MCI's most diplomatic and persuasive staff to assuage the commanders' concerns. This was an ongoing effort, as the military situation was extremely unstable during the span of this project.

LESSONS LEARNED

Relationships with commanders

Several important lessons may be drawn from MCI's experience in conducting medical training programs geared to supplying health workers to a war zone. The atmosphere of extremely volatile political, military, and tribal loyalties required MCI to maintain an unimpeachable reputation for fairness and neutrality. Only in this way was it possible to initiate and maintain programs. For credibility, MCI's impartiality had to be seen to extend to all aspects of its operations. This included seemingly pedagogical concerns such as student selection. After a period of trial and error, it became obvious that involvement of the Board of Directors, and a definitive entrance examination

were both needed to ensure adequate caliber of students who would have political support to work in their home communities.

Utility of a flexible curriculum

MCI also learned valuable lessons regarding other, more strictly academic subjects. For example, the flexibility to use a dynamic curriculum was very important. As conditions in SW Afghanistan changed over the time span of this Cooperative Agreement, this flexibility allowed the Training Staff to respond to evolving clinical needs in the target population. Specifically, while first aid and immediate treatment of the war-injured were emphasized in the early days, as hostilities lessened, the primary health needs of the population became more evident. Increased stress on primary health and prevention were incorporated into the curricula, thus establishing a more substantial basis for providing health care over the long term.

Advantages of inter-agency cooperation

The benefits of inter-agency cooperation in conducting training was an additional instructive area for MCI during this project period. With several other NGOs conducting medical training programs, providing health workers to Afghanistan, and administering clinical facilities, two important lessons were learned. First, standardization of courses greatly simplified administration of clinical facilities, as well as assured the quality of care. Secondly, the cooperative efforts of individuals from a number of NGOs and other agencies also served to improve the quality of the training material. The formation of the Core Group proved to be a useful step in creating a forum for this cooperative activity. The Core Group activities extended beyond the preparation of training material; Core Group policies on student selection, administrative and financial matters were also established. These policies were widely accepted, as it was known they were consensual. Again, in the political climate in which MCI operated, this was an important strength.

Important aspects of field support of students

MCI's experience with monitoring and debriefing students was also informative. This method of providing field support to the students proved invaluable. Not only was the basic curriculum rigorously tested in this way, but the capabilities of the students in field conditions was also assessed on a regular basis. The desirability of continuing education, refresher courses, and the ongoing support of trained workers was convincingly demonstrated, and led to policies to accomplish this.

ACTIONS FOR SUSTAINABILITY

In the early days of the project, expatriate staff were essential for the institution and management of the medical training programs. Over time, the expatriate staff assisted local staff in management and direction of the training programs. By July 1992, MCI reduced the number of international staff in training programs from 6 to 0, while the quality of the training programs continued to improve. The formation of the Core Group was an essential component of this. Furthermore, the production of books, handouts, flip-charts, and other training material, and their translation into Dari and Pushto are important lasting contributions of this work.

The provision of trained, competent, and responsible health workers for SW Afghanistan was an immeasurable contribution of the training programs, which will impact the people of the region for as long as the health workers continue to practice.

III. AFGHANISTAN HEALTH CENTERS

INTRODUCTION

The overriding goal of the Medical Help Project for SW Afghanistan was the delivery of health care services to the war-affected population. To accomplish this goal, MCI established 54 health centers and supplied many hundreds of trained health workers in nine provinces of SW Afghanistan from 1986 to 1993 (see Annexes 7-10). Under the terms of the Cooperative Agreement with USAID signed in 1991, MCI supported 39 health facilities, and planned to initiate MCH annexes in those clinics with a female health worker on staff. Subsequently, during 1992 - 1993, the health facilities were reduced due the withdrawal of funds by USAID, and to eliminate duplication of services in the areas of high coverage.

These health facilities were established in the targeted provinces (initially nine provinces, later reduced to eight) in collaboration with local commanders. Nearly all the staff for these facilities were trained by MCI in Quetta in a variety of programs, i.e., the mid-level health worker program which included training for outpatient department (OPD) workers, and dental, laboratory, and x-ray technicians.

MCI health care delivery programs also included construction of health centers, reconstruction of damaged facilities, and rehabilitation of the health infrastructure in Southwest Afghanistan. Some of these tasks were funded by WHO.

OBJECTIVES

1. To establish a system of health facilities inside Afghanistan; organize a functional referral network
 2. To staff with qualified health workers; to monitor their field performance
 3. To provide all the necessities for a functioning clinic, including medicines and supplies, equipment and spare parts, and resupply as needed
 4. To promote sustainability by a future Afghan government or private system
- 35

ACCOMPLISHMENTS

Establish a system of health facilities inside Afghanistan; organize a functional referral network

A system of 39 separate health facilities was established inside Afghanistan. These facilities included: 28 clinics staffed by nurses and mid-level health workers, 6 comprehensive clinics staffed by doctors, 3 small hospitals, and 2 basic health posts staffed by basic health workers. With these facilities, delivery of health services to more than 250,000 patients per year was achieved. The total target population in the 8 provinces of Southwest Afghanistan was 1,500,000 individuals; thus 1 in 6 people were served each year by MCI-administered facilities.

These facilities were organized into a referral network which provided increasing levels of care and medical backup. For example, mobile units staffed by BHWs were connected to specific C-2 clinics; in turn these were connected to nearby C-1 clinics. Clinics then related to the small hospitals. Al-Jehad Hospital in Quetta then served as a tertiary level of hospital care for complex, difficult patients.

In addition to these basic facilities, MCI also operated 2 orthopedic rehabilitation workshops, in Kandahar and Helmand provinces, in cooperation with OHI. Eight patients per month were fitted with foot or leg prostheses. Furthermore, MCI also operated 3 MCH annexes, in Kandahar and Urozgan provinces. The Khakrese Kandahar clinic was staffed by an MCH assistant trained by MCI, the other clinics were staffed by experienced women hired locally. These annexes were attached to existing clinics; each was managed by one female health worker. MCI planned to establish an MCH clinic in the Malestan district of Ghazni province but the suspension of funding from USAID after the kidnapping of U.S. citizens in the region prevented MCI's activities in this area in July 1991 to April 1992.

Table 6
Clinic Designations

	<u>MCI designation</u> <u>(pre-1990)</u>	<u>WHO designation</u>
1. BHW alone	Mobile clinic	C-3
2. Midlevel health worker	C-OPD	C-2
3. Midlevel health worker plus dental or lab technician	B-OPD	C-2
4. Midlevel health worker or physician plus dental and lab technician	A-OPD	C-2 or C-1

Staff with qualified health workers; monitor their field performance

The extensive training program developed by MCI to ensure high quality health care delivery at MCI-administered sites is described above. The students were rigorously tested on multiple occasions during their training, by written, oral, and practical examinations. In addition, a system of field monitoring was originated (see Annexes 11-12). This had two main practical purposes: first, to supervise the operation of the clinical facility, that is to ascertain that it was functioning as planned, that all equipment and supplies were accounted for, and that all personnel were performing their specified duties. The second purpose of the monitoring visits was to uphold the standards of care. While the first purpose could be fulfilled by a written report, or a visit by any official representative from MCI, the second purpose required an inspection by a person with ample technical knowledge to assess the situation. Given the difficulties and time required for travel in Afghanistan, it was not practical to use the Training Staff as monitors on a frequent basis, although they did serve on occasion in this capacity.

MCI therefore solved the problem in four ways. First, MCI insisted on receiving regular written reports from the health workers as a pre-condition for receiving ongoing support. Submission of incomplete reports, or failure to submit reports in a timely fashion were grounds for reprimands and/or termination of clinic support. It quickly became obvious to the health workers that this was an absolute, non-negotiable requirement, and compliance was excellent. Second, a group of non-technical monitors were assigned the responsibility for specific districts in Afghanistan. These individuals tracked the activities function operations of the clinics on a regular basis, and reported any problems. Third, in the fall of 1989, two technical monitors were trained, and began to visit the clinics on a rotating schedule. These individuals were themselves mid-level health workers, but received additional training in supervision and monitoring procedures. Their reports were an excellent supplement to those of the non-technical monitors.

Fourth, and perhaps most important, an innovative system of debriefing was instituted when workers returned to Quetta for resupply. Rather than simply providing the worker with medicines and material, this visit to Quetta was used as an opportunity for intense and in-depth review of clinic operating procedures. Health workers were required to bring written documentation of all clinic activities since the last resupply. The worker then underwent a detailed interview, lasting 2-3 hrs at a minimum, reviewing any and all aspects of the clinic operations with the debriefing team (an Afghan training physician and an expatriate member of the training staff). Topics discussed could include: diagnoses made (and how these were substantiated), medications used, community work accomplished, goals for improvement, staffing problems, public health issues in the community, and security. This system, once in place, was extremely fruitful. As the Debriefers became more experienced in eliciting information in this format, many problems with the inside clinic operations could be identified and solved, with followup assured at the next resupply visit. Furthermore, based on this in depth review of the clinic activities, the resupply given to the clinic could be adjusted according to actual use.

Provide all the necessities for a functioning clinic including medicines and other consumables, equipment and spare parts, and resupply as needed

These accomplishments are discussed in Section IV Logistical support: Medicines and Material aid and Annex 13.

Promote sustainability

Initially, the health system in SW Afghanistan was so thoroughly destroyed that complete rebuilding was necessary. Once the rudiments of a functional health care system were re-established, plans for sustainability became a concern. One goal of MCI's field support and supervision was to encourage the confidence of the medical workers in their own abilities to carry out their duties. On a more practical level, basic management skills were taught during the training courses so that health workers had received rudimentary instruction in clinic management. This again was emphasized during field monitoring and debriefing sessions, with the aim of fostering the independent management skills of the health workers. As time progressed, MCI support of the clinical facilities was gradually withdrawn, starting with introduction of fee-for-service, stepped reductions in salary support, and then followed by withdrawal of external supports for clinic operations such as fuel, food, and transportation costs. It was hoped that these gradual reductions in subsidies would enhance be counterbalanced by increases in revenue generation. Until the close-out of the project in 1993, drugs and supplies were furnished to each facility.

CHALLENGES AND CONSTRAINTS

Political neutrality and establishment of solid working relationships with the local commanders were critical factors in the installation of MCI's clinics in Afghanistan. Maintenance of this reputation was an ongoing challenge, subject to numerous pitfalls. In some districts, relationships with commanders became too difficult to proceed, thus MCI had to withdraw from the area. Fortunately, MCI was able to build and maintain solid working relationships in many regions, but this was a "balancing act" of diplomacy that required renewal nearly on a daily basis.

The difficulties with the development and institution of an effective, informative field supervision and monitoring program were additional challenges. Some obstacles included the questionable reliability of field reports, the uncertain credibility of health worker reports, and in early days of operation, even identification of the physical location of the clinic was sometimes difficult, as security concerns often prompted evacuation from an area. However, such solutions as the placement of trained technical monitors in the field, the insistence on a high quality of the interim reports from the clinics, and the development of the debriefing system all served to overcome these difficulties.

Internal organizational problems also affected the implementation and supervision of MCI's clinical facilities inside Afghanistan. Initially, clinical locations were determined with the guidance of two Afghan staff members. These staff members, both sincere and well-meaning, also initially supervised the supply of the clinics, and all MCI communications with the commanders. It became apparent that no other MCI employees had access to the clinics for adequate regulation and oversight, needed because these individuals were not trained as health workers. Eventually, these individuals resigned, and more regular communications by MCI technical staff could be instituted.

One problem which could not be overcome was the absent infrastructure in SW Afghanistan. Combined with military instability, travel, communication, and any contacts were at times extremely difficult or impossible. Although MCI aimed at technical monitoring of each clinical facility every three months, this could not always be accomplished due to these often insurmountable barriers (see Annex 11). Fortunately, non-technical monitoring was performed every 3 months or more frequently.

Only the passage of time will prove the effectiveness of the measures taken to encourage a sustainable health care system. USAID provided specific directives for the institution of these measures. Although these measures were clearly needed, the timing by which they were instituted was often problematic for the clinics involved. While MCI's non-technical monitors could explain the requirement for these changes during their visits to the clinical facilities, full discussion of their rationale often could not be accomplished because of the barriers to free communication with the clinics. A better understanding by MCI of the long-term goals desired by USAID at the time of initiation of these programs would have been helpful in planning and the exchange of information with the clinics.

LESSONS LEARNED

Most important to the success of MCI's entire project was its reputation for political neutrality and fairness. Implementation of a complex cross-border program operating in a country stricken by civil war required the utmost diplomacy and tact. Instability, active combat, and later on, civil war among many different political parties greatly increased the complexity of the situation. The lack of physical infrastructure, any central force for law and order, and any governmental regulations made the personal relationships developed by MCI employees essential to program success. The prudence, discretion, and clear-mindedness required for this task should not be underestimated.

Of necessity, most MCI clinics were connected to a strong commander in each area. This had positive and negative facets. Positive benefits included support of the goals of the clinic, and security of personnel and property. An unfortunate corollary of this arrangement was that many commanders then felt themselves to be empowered with administrative control over clinic operations. Introduction of new programs, replacement of staff, relocation of the facility, or even trivial decisions such as changing equipment in the clinic were often met with opposition and a refusal to comply. Again, personal relationships built by MCI staff members were the only way by which these conflicts could be resolved.

Community participation and support was another element critical to success of MCI's programs. It was necessary to discuss and explain the project objectives with community leaders prior to the acceptance of MCI programs in each district. Approval of the project goals by the community was crucial to their achievement. This was particularly true in relation to MCH

activities, which might not have been accepted without adequate advance explanation.

In retrospect, MCI recognizes that it would have been beneficial to clarify to recipient communities that its programs were to be of limited duration, and that MCI was subject to outside authority (USAID) in making the determination of not only the lifespan of the program but also of some critical programmatic elements. For example, as directed by USAID, MCI began to decrease direct financial support for its health facilities in 1992, and to attempt to promote community cost-sharing of these enterprises. Considerable difficulties were encountered in explaining why programs which had been fully subsidized were, with little or no warning, faced with loss of all or part of this support. At the community level, the apparent "sudden" and "arbitrary" nature of these changes did not reflect well on the United States, and may in some cases have undermined previously favorable impressions of the U.S.

ACTIONS FOR SUSTAINABILITY

Although initially all clinic activities were fully subsidized, these subsidies were withdrawn over time. By July 1992, MCI reduced operating costs of all clinics and hospitals by 20%, by revising the types and quantities of pharmaceutical and medical supplies, and the system for their distribution. Furthermore, salaries for all health workers were adjusted in accordance with the standardized levels approved by Afghan authorities (MOPH and AHSAs [Area Health Service Administrations]). In 1992-1993, salaries were further reduced by 50%, and all additional support was discontinued. Clinics were encouraged to transition to a fee-for-service system, while MCI encouraged community support.

By June 1993, support for 11 "redundant" clinics was completely withdrawn, and administration and control of 3 additional facilities was transferred to local health committees.

By the conclusion of this project, all remaining facilities were able to generate income or find other sources (in some cases, local commanders) for financial support. MCI now has received reports that some former clinics remain active as long as one year or more after the withdrawal of support. While maintenance of the quality of care cannot be verified, it is certain that the former trainees received a solid educational background and that they have access to the training material which was provided during their course.

IV. LOGISTICAL SUPPORT: Medicines and Material Aid

INTRODUCTION

As with the other components of the project, the logistical operations to supply medicines and material aid evolved as time progressed. Initially, needs for medical supplies were minimal, and all supplies were purchased locally in Quetta and stored in and distributed from the MCI warehouse. In 1991-1992, MCI participated in the Combined Procurement System with MSH. Under this system, 25 major medical items were purchased by RONCO, and then delivered to MCI's Quetta warehouse by MSH procurement staff. The remaining items of the standard resupply lists were purchased locally. In December of 1992, the Combined Kit System was introduced; this supply method was then used until the conclusion of the project in 1993. Through this system, 100% of medical supplies were delivered by MSH's procurement office to MCI; all items not supplied by MSH were discontinued.

OBJECTIVES

1. To provide needed supplies and equipment to Quetta-based training programs
2. To provide needed supplies and equipment to Afghanistan-based clinics and health facilities
3. To schedule, arrange, and accomplish timely replenishment of needed supplies and equipment to Afghanistan-based clinics and health facilities
4. To maintain updated inventory of all supplies and equipment
5. To receive, catalog, and distribute all donated supplies and equipment in accordance with the requirements of each donor
6. To maintain security of all supplies and equipment, in Quetta as well as during transport to Afghanistan

ACCOMPLISHMENTS

Provide needed supplies and equipment to Quetta-based training programs

MCI established a warehouse based in Quetta for receiving and issuing medical supplies and equipment for the project. A procurement officer was in charge of purchasing supplies as requested by the medical department. Lists of needed materials were submitted to local suppliers for bids. These bids were then used as a basis for purchase decisions. Ongoing replenishment of supplies, medications, and equipment for 3 active clinical facilities was a major task of the logistic operations department. With as many as 500 patients seen each day at the OPD and MCH clinics, regular resupply of frequently needed items was required. These items included medicines, equipment, and instruments. Occasionally, trips outside of Quetta were necessary to locate specific items. Supplies and consumables were also used by Al-Jehad hospital, by the students during training, and by the dormitory staff.

Provide needed supplies and equipment to Afghanistan-based training programs

Once clinic sites were established, an assessment of equipment needs was made. Supply needs were pre-determined based on the level of the health facility, and were standardized for all MCI facilities. At the beginning of MCI's operation of the clinic, the supplies and equipment were delivered, often by the returning newly trained student.

Schedule, arrange, and accomplish timely replenishment of needed supplies and equipment to Afghanistan-based clinics and health facilities

This task was considerably more challenging for the logistics operations department. Most clinics were resupplied every four to six months. Standard resupply lists for each type of health facility were compiled by the Coordination of Medical Committees (CMC), of which MCI was an active member. According to schedule, the warehouse prepared a four or six month supply for each clinic. Because of the distances involved, two clinics located in Farah province were resupplied on every nine months. The representative from each inside clinic came to Quetta and received his resupply issue. The tea-chest containing the supplies was packed in the presence of the clinic representative and an MCI warehouse employee, who both signed attesting to the contents. The tea-chest was then secured, and delivered by MCI

to the distribution center in Boldak, Afghanistan (near the Pakistan border). The clinic representative then was responsible for collecting the supplies, delivering them to his clinic, and maintaining security during transport. The transportation costs were covered by MCI.

One of the chief benefits of MCI's debriefing system was that it allowed a readjustment of the resupply issue for each clinic. Debriefing identified any specific needs of the clinic (for example, an outbreak of malaria), verified appropriate drug use by the health workers, confirmed present stocks on hand, and documented any deficiencies. This permitted MCI to customize the resupply for each clinic. The minimal increase in personnel time required to accomplish this was more than offset by the reduction in waste, and the assurance that all items were being used properly.

Maintain updated inventory of all supplies and equipment

With the assistance of the MIS department, an accurate, up-to-date inventory of all supplies and equipment was maintained. At its peak of operation, the warehouse staff kept a register of nearly 1500 items. Information about each item included: control number, description, quantity, price, source, and expiration date. Prior to the development of a computer inventory system, all this information was maintained in files.

Receive, catalog, and distribute all donated supplies and equipment in accordance with the requirements of each donor

During the time period of this project, MCI received donated supplies and equipment from a number of sources including MAP, RONCO/DOD, and WFP. Each donor had specific requirements for the disposition of its items. For example, some items could be used in refugee camps, some could be used in daily clinical activities in Quetta, and some were designated only for use in Afghanistan. Tracking of each item and its proper disposition was an essential responsibility of the warehouse staff. The warehouse also assigned a fair-market value to each item donated if this was not specified when the contribution was received. For example, in 1993 MCI received and distributed donations valued at Rs. 9,430,361 (approximately U.S.\$377,214). It is estimated that in 1990 and 1991, donations valued at Rs. 10-15,000,000 were received and distributed by MCI.

Maintain security of all supplies and equipment, in Quetta as well as during transport to Afghanistan

In the unstable atmosphere of SW Afghanistan, security concerns for large amounts of valuable supplies and equipment were paramount. MCI devised a system of "linked responsibility" so that delivery of each shipment was the clear responsibility of

an individual. Although many other NGOs lost thousands of dollars worth of supplies during transport into Afghanistan, MCI luckily lost only one shipment during this time period of this agreement (In the fall of 1989, an ambush by government troops in Nimroz resulted in the loss of a shipment of medicines, a motorcycle, and spare parts enroute to supply a Mobile Unit in Farah province).

CHALLENGES AND CONSTRAINTS

Quetta-based operations

It was necessary to overcome many barriers to a smoothly functioning logistical operations and supply system during the span of this project. Initially, each clinical facility in Quetta had separate purchasing departments, and coordination among units was poor. The establishment of a central purchasing department based in the warehouse (late 1990) greatly enhanced efficiency, reduced costs, and minimized duplications. Development of a bid system was also instrumental in reducing costs of locally purchased items.

Afghanistan operations

Transport of material to Afghanistan was impaired by several factors, including poor condition of infrastructure (roads, bridges, communications) and extreme weather conditions. Fortunately, MCI's system of transportation within Afghanistan maintained good security of medical supplies. However, ongoing and unpredictable difficulties on the Pakistan side of the border took a great deal of time and effort to solve. Finally, although MCI's warehouse at Boldak was secure, in spite of considerable effort the organization of the warehouse remained substandard.

Inventory

In the time before the warehouse inventory was computerized, maintenance of a complete, updated, accurate record of all items was extremely time- and labor-intensive. To take a complete inventory required 2 people working for 10 complete days. With the institution of a computerized system, inventory could be completed in less than one day.

LESSONS LEARNED

It became evident that several components were required for smoothly functioning warehouse and logistical operations. In addition to an adequate computer system, it was essential to have highly qualified personnel. The warehouse supervisory staff all had medical backgrounds (pharmacy or nursing), and thus were familiar with medical supplies and terminology. They also had, or developed, expertise with computer databases and excellent supervisory and management skills. The value of on-the-job training for staff at all levels was also apparent. Finally, the importance of assigning the sometimes-difficult task of government relations to a single individual also became clear. This person then could develop relationships with appropriate officials over time, and greatly ease some of the bureaucratic difficulties that were encountered.

ACTIONS FOR SUSTAINABILITY

With the down-scaling of MCI's medical operations, the activities of the warehouse/logistics departments have also diminished. Nonetheless, the legacy remains of a number of people who have had the opportunity to develop and expand their skills in organization, office management, supervision, computer use, and record-keeping.

. 4/1

V. ADMINISTRATION

INTRODUCTION

The Medical Help Project for SW Afghanistan was developed to provide trained health workers and to administer health facilities in a war-torn country. In support of this project, MCI/Quetta developed an administrative structure to oversee planning and management, as well as facilitate program operations (see Annex 14). Communications with the host government - the Government of Pakistan, and with the myriad mujahadeen commanders and political parties active in SW Afghanistan (and Quetta) were additional important functions of MCI administration. Furthermore, ongoing frequent communication and cooperation with both MCI's Portland headquarters and with USAID were also required. Over the span of this project, MCI/Quetta created an administrative structure that achieved these goals. Furthermore, the inclusion of Afghan staff within the administration was an important contribution to sustainability.

OBJECTIVES

1. To promote project goals by providing necessary planning, management, financial, and logistical support
2. To facilitate communications with the host Government of Pakistan regarding operations, expatriate personnel, financial and legal requirements
3. To facilitate communications with military and political leaders in SW Afghanistan
4. To maintain communication and cooperation with USAID
5. To maintain communications with MCI Portland headquarters
6. To establish a structure with potential for sustainability

ACCOMPLISHMENTS

Develop an organizational structure for MCI/Quetta

The Medical Help Project for Southwest Afghanistan was the first project undertaken by MCI in Quetta. Therefore, it was

necessary to develop a complete administrative structure. As the complexity of the program increased, the organizational structure of MCI's administrative staff underwent successive alterations. When operating at full capacity, this administrative staff included the Country Director and the medical director, assisted by expatriate medical and Maternal Child Health advisors. The medical director supervised the Directors of the Training Program, the OPD, Al-Jehad Hospital, the MCH Clinic, and Inside Operations. The Country Director devoted 50% of his time to the medical project, while the remaining staff worked full-time on the project. This core staff was supported by additional administrative backup, including the finance department, the warehouse manager, and the MIS division. The organizational chart of the Quetta-based health administration is shown in Annex 15.

Facilitate communications with the Government of Pakistan

It was recognized early in the course of MCI's operations in Quetta that good communication with the host government was essential to carry out the goals of the project. In the early days of the project, considerable difficulties were encountered with Pakistan governmental regulations regarding receipt of shipments of supplies and material from overseas, transport of these supplies over roads in Pakistan, border crossings between Afghanistan and Pakistan for personnel (Afghans and expatriates) and supplies and equipment, and various expatriate issues including visas, work permits, and assurances of safety. Various means were found to deal with these issues. For example, O/AID/REP assisted with obtaining a route-permit to allow transport by road of various equipment and supplies. Initially, extensive delays were encountered in receiving shipments through Pakistan customs. In one memorable case, a large shipment of needed medical supplies was delayed for 14 months at customs. Finally, after extensive negotiations with various officials of the Pakistan government, later shipments were received through customs with less extreme delays.

Additional negotiations were necessary to approve transport of items across the Afghan border. Although a general approval was received in the second quarter of 1989, often these shipments had to be resolved on a case-by-case basis. Cross-border transport of personnel, particularly expatriates, was occasionally met with difficulties on the Pakistan side. One example occurred in the fourth quarter of 1988. After 6 months of planning, an expatriate medical team specially recruited and assembled by Aide Medicale Internationale (AMI) to monitor all of MCI's health facilities in Afghanistan (planned to take 2 months) was not permitted to cross the border. Other expatriate issues were successfully managed by an administrative staff member who met regularly with government and police officials to review visa status and work permits.

Facilitate communications with military and political leaders in SW Afghanistan

During the span of this project, SW Afghanistan was completely disrupted by war. At different times, various rival factions controlled different areas. During one time period, the section of road between the Pakistan/Afghanistan border (Spin Boldak) to Kandahar city was blockaded by no fewer than 70 chains, each controlled by mujahadeen demanding satisfactory "credentials" of any vehicles which wished to pass. To work successfully in these conditions was a challenge requiring the utmost sensitivity. These conditions affected all aspects of MCI's health operations, including establishment, supply and resupply, and safety of clinics and other health facilities. Security concerns for personnel (including students and monitors), and for supplies, equipment, and property were paramount. The general approach taken by MCI administration was to maintain neutrality with all parties rather than to ally with the most powerful.

Political and military divisiveness extended to some aspects of MCI's Quetta-based medical programs as well. For example, selection of students to be trained was a highly political decision for many reasons, including the fact that it was necessary for local commanders to guarantee the security of the clinic and its personnel, as well as to assist in choosing students who were most likely to return to their villages to work. Thus, many of the political and military parties felt they possessed a vested interest in the management of the training facilities in Quetta. To solve these problems, MCI developed the innovative plan of convening a Board of Directors composed of representatives of these political and military interests. Communication with this Board of Directors was instrumental in allowing MCI to function successfully in this unstable, politically charged environment.

Initially, the Board of Directors reviewed, endorsed, and provided policy guidance for the implementation of proposed medical projects. This included assistance with the selection of the location of planned health centers, approval of the administrative and organizational guidelines for the health centers, and some review of the inspection reports of the clinics' activities. The Board of Directors was an essential component of the negotiations with Jamiat which allowed the association of MCI with Al-Jehad Hospital. With increasing evidence of MCI's political neutrality over time, and therefore fewer sensitive issues to discuss, the Board of Directors gradually dissolved.

Maintain communications and cooperation with USAID

An essential component of the Medical Help project was the

maintenance of ongoing communications and cooperation with the donor, USAID. This occurred at two levels of MCI's administration: Quetta and Portland. In Quetta, this communication included a number of elements: (a) weekly reports from the medical section faxed to USAID Islamabad, with updates on Training Programs, Clinical Facilities, and Inside Operations, (b) quarterly reports sent to USAID Islamabad, with detailed reports of all accomplishments and difficulties of the previous quarter, work plans for the coming quarter, and complete financial records, (c) regular phone contact with USAID Islamabad personnel regarding any issues or difficulties which arose in implementing the work plan, and (d) frequent face-to-face meetings of USAID and MCI staff to discuss and update the project implementation.

MCI's Portland Headquarters Staff was also involved in maintaining contact with Washington, D.C. based USAID officials regarding MCI/Quetta's programs for Afghanistan.

Maintain communications with MCI Portland headquarters

MCI's Quetta administration was further supported by MCI's Portland operations. This included the Portland Afghan Desk Officer, the Asia Regional Director, and the Vice-President for International Programs. Individuals in these positions provided ongoing advice and coordination of all programs, finance, and personnel activities between MCI/Portland and Quetta. The Portland Office determined appropriate field policies and procedures. The Asia Regional Director remained in close contact with the Country Director. MCI/Portland staff were also involved in maintaining contact with relevant US State Department and AID officials, congressional staff, and other contacts regarding MCI/Quetta programs for Afghanistan. The organizational structure of these positions is shown in Annex 15. USAID support for the position of Afghan Desk Officer was discontinued in July 1993.

Cooperate with other agencies

An additional task of the administration was to enhance cooperation with other agencies working in the area. During the span of this project, there were numerous other agencies with interests in assisting Afghan refugees. To foster cooperation, rather than competition, MCI participated in several committees composed of representatives from various agencies. Two important examples of this were participation in SWABAC and the CMC. In the first, assistance activities and establishment of health facilities could be coordinated with other SWABAC-participating agencies. The CMC was a productive work group which accomplished the significant tasks of developing and standardizing several curricula to train health workers. The published texts of these curricula, manuals, and formularies attest to the success of this

committee, and MCI's participation.

In addition to these activities, frequent discussions occurred with the numerous other agencies active in the area. A partial list of these agencies includes: ICRC, MSH, SCA, OHI, UNICEF, WHO, IMC, RONCO, WFP, UNDP, IAHC, ICM, AMI, ACBAR, AVICEN, AICF, UNHCR, and UNOCA. Such work was critical to program development and implementation, and often resulted in cooperative arrangements beneficial to both parties. An example of this is the cooperative agreement between MCI and OHI to train prosthetic workers, and jointly operate a clinic in Baghran. Furthermore, inter-agency cooperation enhanced MCI's role in the NGO community.

Establish a structure with potential for sustainability

Along with oversight of daily operations and planning program implementation, a main objective of the administrative team was to install and train Afghans in the various departments of operation. Over the span of this project, MCI succeeded in placing Afghan staff in management positions, and reducing the number of expatriate staff. Many additional Afghan staff gained administrative and managerial experience working on individual projects. By mid-1992, the number of expatriate staff directly involved in management positions was reduced from eight to three. The final expatriate staff at the end of 1993 included the Country Director (half-time) and the MCH/Acting Medical Advisor.

As part of its efforts to upgrade management skills of national staff, MCI conducted three in-depth seminars for a selected staff in the areas of grant management, budget procurement, and consultants/sub-contractors. These seminars were conducted in Quetta by the MCI senior staff from Portland headquarters.

CHALLENGES AND CONSTRAINTS

Establishment of a workable administrative structure was a significant challenge given the climate of political turmoil, military instability, and lack of experience in the area. Although MCI surmounted these problems, some of this was (necessarily) accomplished by painstaking trial and error. One area of difficulty in the administration of MCI was the numerous staff changes. During the seven years of the project, there were four Country Directors (see Annex 16). Similarly, there were numerous other changes in expatriate staff members both in Training Staff, Medical Advisor, and MCH Advisor positions. During some periods, these positions were vacant for months.

Such episodes inevitably resulted in loss of momentum and continuity of program implementation, although with the excellent abilities of Afghan managerial and field staff, this was minimized. Some episodes, such as the evacuation of all expatriate staff during the Gulf War, were out of the control of MCI.

LESSONS LEARNED

The utility of convening a Board of Directors to provide input to medical operations was clearly proven to be effective in the challenging political atmosphere. The rigorous maintenance of political neutrality was also essential to allow operations to proceed. Considerable time and effort were expended to develop working relationships with relevant individuals from SW Afghanistan; the legacy of this effort is the respect enjoyed by MCI for its effective programs.

The successful partnership of MCI and USAID in implementing these programs is a reflection of the efforts on both sides to maintain good communication. With each renewal of the project proposal, care was taken by both sides to ensure understanding of the amendments. As difficulties arose, due to political or military action, close communication became even more essential.

The importance of inter-agency communication was also evident, in view of the large number of NGOs active in the area. Participation in cooperative committees such as SWABAC enhanced the cooperation between various NGOs, allowed sharing of useful information, minimized duplication of efforts, and resulted in improved projects for all participants. Participation in committees such as CMC yielded the tangible results of high-quality, standardized curricula for health workers.

ACTIONS FOR SUSTAINABILITY

With the close of funding by USAID, the administrative structure of MCI necessarily will be reduced. Nevertheless, during the project period, numerous Afghan staff gained valuable experience in management, administration, finance and accounting, and logistical operations. Many staff developed or improved their English-language and computer skills. Seminars and workshops on grant-management, budgets, and consultants/subcontractor issues were conducted by senior

Portland staff. Since the withdrawal of USAID funding, some proposals prepared by Afghan staff have already been successfully funded by other donors.

VI. MANAGEMENT INFORMATION SYSTEMS

INTRODUCTION

In support of MCI's goals of training health workers, monitoring their field performance, and administering and supplying clinics and hospitals in SW Afghanistan, an MIS department was established in Quetta. This program eventually employed 11 people, and furthermore trained more than 60 individuals in basic computer literacy. Individuals with Pushto and Dari computer skills were integral members of the MIS department. The program was established with the following specific aims:

OBJECTIVES

1. To facilitate communications and record-keeping
2. To support the medical worker training program
3. To support activities of Quetta-based clinical facilities
4. To maintain records of activities of Afghanistan-based facilities
5. To support logistical operations including medicines and material aid
6. To enhance the computer literacy of MCI staff

ACCOMPLISHMENTS

Facilitate communications and record-keeping

The MIS department was instrumental in assisting the administrators and health managers with their regular communications with USAID, Portland headquarters, and amongst the various cooperating agencies. In addition to assistance in preparing professional reports, the MIS department entered, organized, and analyzed a considerable amount of the data upon which these reports were based.

The MIS department also established, updated, and maintained personnel records for all employees in health sector. This

information included such items as date of hire, attendance, salary, vacation, benefits, and any performance reviews.

Support of Training Program

The support by the MIS department to the Training Program was two-fold. First, considerable assistance was rendered with the didactic component of the the Training Program. This included assistance in preparing the training material, such as booklets, handouts, lesson plans, diagrams, and flip-charts. In addition, the multilingual translators with knowledge of medical terminology in the MIS department were responsible for translation of these materials.

Furthermore, the MIS department maintained records of all courses given, the students attending the courses, supplies utilized in training, and all records pertinent to the operation of the dormitory.

Support of Quetta clinical facilities

The daily operations of the clinical facilities were also catalogued, entered, and analyzed by the MIS department. These clinical facilities were quite active, often caring for over 500 outpatients each day in addition to inpatients. Numbers of patients seen, diagnoses, numbers of laboratory tests, treatments given were collected and analyzed for each provider and each facility. This enabled MCI to record trends in diagnoses and treatment (as required by UNHCR and PDH), and to track the performance of each individual health provider.

Support of Afghanistan Operations

One of the major objectives of the MIS department was to assist with the enormous volume of data necessary to track the activities of MCI administered health facilities inside Afghanistan. This included the records of clinic equipment and supplies, and clinic staffing. Dates of resupply and intercurrent problems were also recorded. The schedules for the monitoring program was also the responsibility of the MIS department. Records of the dates of monitoring and debriefing were maintained by the MIS department, along with the reports of the status of each clinic throughout its existence. These reports are reviewed more completely under "Inside Afghanistan Operations", and an abbreviated version is included in Annex 12.

A further function of the MIS department was in carrying out the mapping program as requested by USAID. This required a substantial leap in the computer skills of the staff. The use of sophisticated software was successfully accomplished, and accurate mapping of all MCI facilities was obtained.

Support of logistical operations

MCI's operations in Quetta and Afghanistan required considerable logistical support. MIS assisted by establishing, supervising, and "trouble-shooting" programs by which logistics staff maintained an updated inventory of supplies, a record of income and expenses (in conjunction with Finance Department), and a register of purchases.

Increase computer literacy of MCI staff

As a by-product of the above activities, more than 60 individuals developed and upgraded their computer skills as well as their English language skills. These included members of the Training Staff, the MIS Staff, and the Management Staff.

CHALLENGES AND CONSTRAINTS

The computer needs of MCI grew exponentially as the complexity, size, and scope of operations expanded. Initially, few skilled computer-literate individuals were available in the Quetta area. However, MCI was able to develop an internal training program which successfully allowed capable individuals to learn "on-the-job". These individuals strengthened their English language skills, database management, and proficiency with various types of software. The establishment of computer systems with sufficient sophistication and flexibility to accomplish the desired goals was a process of trial and error, as the needed outputs changed over time. Moreover, it was necessary to develop programs with easy "accessibility", as many computer functions were needed by individuals with considerably less computer experience than the MIS staff. Development and use of multilingual computer programs was an initial difficulty which was surmounted. Not as easy to surmount was the problem of training field monitors to collect "computer-ready" data. Individual training sessions with field monitors was necessary to ensure correct data collection. An additional challenge was faced with some warehouse staff members with poor educational background. Again, review of data for accuracy prior to entry was necessary.

There was a great deal of interest amongst MCI staff in upgrading their computer skills. However, shortages of computer terminals for practice, and deficient English language skills were significant problems. Lack of technical support for the MIS staff was a major challenge. There was no assistance or backup for any software or hardware problems which arose in Quetta. Thus, the staff had to problem-solve without any support. This

was a particular problem with the use of the PICK operating system, which was selected for database management. Not only did this system turn out to be difficult to learn, but also difficult to trouble-shoot. PICK also turned out to be extra-sensitive to the frequent power fluctuations in Quetta. Nonetheless, these problems fostered the growth a talented, highly knowledgeable, and extremely skilled group of individuals. In addition to their expert computer skills, this group of individuals also acquired proficiency in service maintenance, and minor maintenance and repairs.

LESSONS LEARNED

Internal development of staff was a successful strategy for the MIS department. This system developed loyal, knowledgeable, and versatile employees. The "organic growth" of the department had the strength that the computer systems grew as needed, the quality of data was assured, and duplication of efforts and services was minimized. The major lesson was that needed output from MIS was not always planned in advance; improved definition of required output at the onset of a project would have been helpful.

ACTIONS FOR SUSTAINABILITY

In addition to the development of a highly qualified MIS staff and the improvement in basic computer literacy of a large number of other staff, the MIS department leaves a legacy of an enormous database cataloging MCI's medical activities over seven years. These data include the actual clinical reports on a daily basis from a large number of health facilities in Pakistan and Afghanistan: a rich source of epidemiological information. Such data are potentially of great use for future health system planning.

ANNEX 1

SPECIFIC OBJECTIVES FROM USAID FOR MCI MEDICAL
PROGRAM 1986-1993

ANNEX 1**SPECIFIC OBJECTIVES FROM USAID FOR MCI MEDICAL PROGRAM 1986-1993**

On July 1, 1986, Cooperative Agreement No. 306-0211-A-00-1214 was established between the United States Agency for International Development (USAID) and Mercy Corps International (MCI). The terms of the initial agreement were to:

1. Conduct four 3 month first aid training courses to train 140 medics
2. Conduct two 6 month advanced medical assistant courses to train 80 senior medics
3. Establish 11 health centers in SW Afghanistan
4. Provide material aid in support of these clinical facilities
5. Involve 7 major political parties, establish a Board of Directors
6. Prepare for second phase: expand medical services, education program, agriculture, management, finance, computer training

Under the terms of this useful and productive collaboration, a successful program for training health workers was developed, and a series of clinical facilities were established and administered to serve the people of Southwestern Afghanistan. In the context of the politically unstable and insecure military environment of SW Afghanistan in the late 1980's and early 1990's, the accomplishments of this project were remarkably successful. A Cooperative Agreement to continue these projects was therefore signed in 1991, with the following major objectives:

OPERATIONS

1. Operate Al-Jehad Hospital and MCH Clinic as training facilities (phase out all activities not in support of training)
2. Support 39 existing health posts, clinics, and small hospitals
3. Establish a MCH facility at Malestan, Ghazni after September 1991 to be staffed by female workers trained by MCI
4. Establish 6 MCH wings in association with existing health facilities
5. Provide supervision/technical assistance/refreshing to its health workers as needed
6. Establish a mobile MCH team to work inside Afghanistan at centers without specific MCH facilities
7. Institute revenue generating activity at 34 facilities inside Afghanistan and at the Quetta-based facilities
8. Establish EPI services at the 6 MCH wings (but obtain vaccines from UNICEF or other sources)
9. Participate in combined procurement system with MSH and IMC
10. Operate computer-based Health Information System to track services provided, supplies, personnel, and operating costs

51

TRAINING

1. Complete the seventh and final one year course
2. Conduct up to six refresher courses for mid-levels
3. Train up to 10 female MCH workers, and begin training next 10
4. Train female workers in vaccination techniques

AFGHANIZATION/PORTABILITY

1. Conduct 3 in-depth training seminars for selected Afghan staff on "Grant Management", "Budget Procurement", and "Consultant/Subcontractors"
2. Continue to "Afghanize" staff
3. Develop a written plan to form an Afghan NGO to operate MCI's health facilities
4. Provide a detailed written plan to O/AID/REP on the move of medical training activities to Kandahar

Amendments to this Agreement for the 1992-1993 grant year include:

OPERATIONS

1. Reduce the number of health facilities inside Afghanistan
2. Operate 2 MCH facilities: Malestan and Lashkagar
3. Establish 3 MCH annexes at existing facilities and develop a referral system for perinatal care
4. Expand MCH activities as more female health workers become available
5. Turn over the operation of 9 clinics to established Health Committees
6. Operate EPI teams from 9 health facilities
7. Operate two prosthetic workshops (Baghran and Panjwail)
8. Order all medical supplies through the combined procurement system
9. Move all operations inside Afghanistan within 6 months after requested by O/AID/REP

TRAINING

1. Conduct 4 CMCEP courses - 2 concurrently with 20 students each
2. Train 21 female health workers, but not until a standardized course is approved
3. Participate in the coordination of a Field Microscopist continuing education program
4. Coordinate EPI activities with MSH, SCA, AVICEN, and the AHSAs

AFFORDABILITY

1. Complete a cost-containment plan

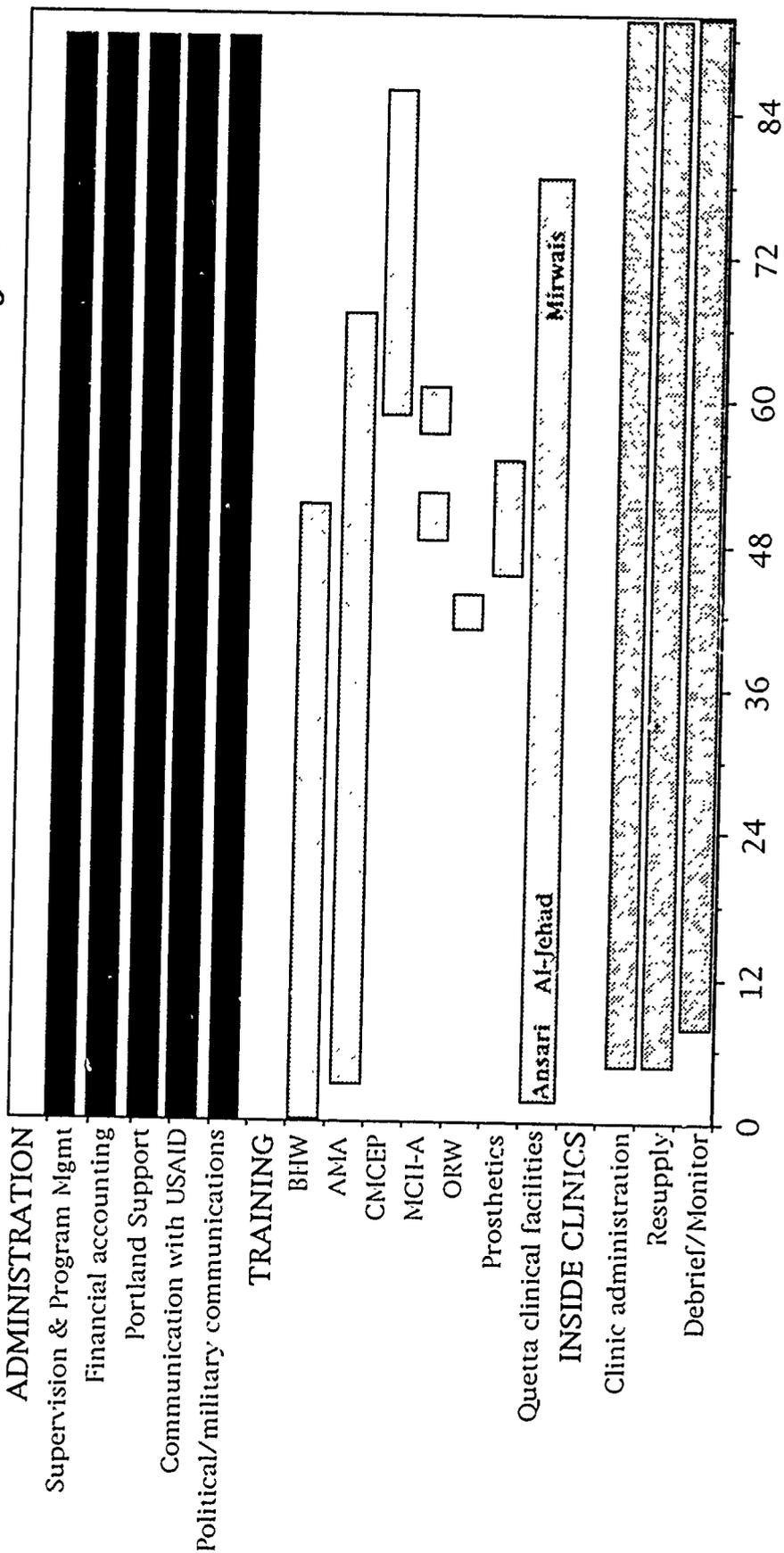
2. Standardize salaries according to those approved by Afghan authorities
3. Reduce salaries of all service delivery and support staff by 50%
4. Conclude distribution of benefits including food, fuel, and maintainance

Finally, in April 1993, MCI received the directive from USAID to phase-out all medical programs. Activities in Afghanistan were to be concluded by October 31, and activities in Quetta were to be concluded by December 31, 1993. These programs were closed as requested by the designated times.

ANNEX 2

OVERVIEW of MCI MEDICAL HELP PROJECT ACTIVITIES

OVERVIEW OF MEDICAL HELP PROJECT



Months of Project (Jul 1986-Dec 1993)

ANNEX 3

MCI EDUCATIONAL PHILOSOPHY

1.1

ANNEX 3**MCI Educational Philosophy****STATEMENT OF PHILOSOPHY (Second quarter 1987)**

MCI believes in the uniqueness, dignity, and value of people and that it is the right of all people to have the opportunity to receive preventive health teaching and assistance with healing. The provision and teaching of health care must be placed within the students' own cultural and social context.

CURRICULUM

The curriculum for the courses must reflect the basic concept stated in the Philosophy:

- Dignity and value of people
- Prevention
- Healing
- Culture/society
- Teaching/learning

Students will need to be trained in the following:

- The dignity, value, and rights of people
- The process of learning
- The process of teaching
- Cultural and social specifics that impinge upon health care
- The ability to recognize and assist in diagnosing certain health care problems
- The ability to assist in providing health care and preventive health care teaching

ANNEX 4

CHRONOLOGY OF TRAINING AND STAFF DEVELOPMENT
ACTIVITIES

ANNEX 4**CHRONOLOGY OF TRAINING AND STAFF DEVELOPMENT ACTIVITIES****1986****Fourth quarter**

- *Established relationship with Ansari Hospital to use as training facility
- *First 3 month first aid course concluded; second course started with 51 students
- *First 6 month Advanced Medical Assistant course started
- *Arranged to use Al-Jehad facility for additional training site and dormitory accommodations

1987**First quarter**

- *Board of Directors formed to assist in medical program
- *First expatriate medical worker arrives
- *After extensive review, relationship with Ansari Hospital is terminated
- *Curriculum committee is established to oversee organization of courses
- *21/26 graduates from second 3 month course supplied
- *Practical training for first 6 month course begun
- *Additional course material on leprosy added
- *Satisfactory resolution of two strikes by students
- *Established objectives for 6 month training course and each specialty area

Second quarter

- *Graduation of first Advanced Medical Assistant Course (6 month course), 38/40 students passed
- *Laboratory training extended additional 6 weeks
- *Developed plan to review graduates once they are established in field conditions (in addition to oral, practical, and written examinations administered in Quetta)
- *Located site and developed plans to establish Al-Jehad Training Hospital
- *Developed broad educational objectives for training programs and established guidelines for student participation in MCI training
- *3 month course #3 completed, 29/42 graduated
- *3 month course #4 began with 35 students
- *Tightened screening processes to increase yield of students returning to Afghanistan
- *Developed cooperative agreement between Al-Jehad Clinic and Ansari Hospital (then because of poor conditions, withdrew from Ansari Hospital)
- *First Advanced Medical Assistant Course (6 month course) started with 38 students

Third quarter

- *Renovated space at Al-Jehad Hospital to prepare for opening; OPD moved to new location
- *Fourth 3 month training course ended, 26 students graduated and 21 returned to Afghanistan
- *Fifth 3 month course began
- *Clarified objectives of 3 month course: To recruit first aid workers from resistance and mujahadeen to assist the war-injured
- *Clarified objectives of 6 month course: To recruit experienced first aid workers from Afghanistan, then give 6 month of additional training and return these workers to staff MCI administered clinics
- *Requested and received student evaluations of courses, these comments then used to make appropriate alterations
- *Developed plan to initiate TBA training program
- *Established 6 month course schedule
- *Held regular meetings of curriculum committee

Fourth quarter

- *Created position of Health Training Coordinator, filled by an expatriate and an Afghan counterpart
- *Improved methods of selecting students for MCI training courses, including testing for literacy and general science background
- *Started EPI program
- *Began surgical operations at Al-Jehad
- *Held weekly nursing inservice conferences
- *Completed fifth 3 month course; 26/36 students
- *Suspended 3 month courses in accordance with USAID directive to reduce the duration of these courses to 1 month and use as a pre-requisite for admission to 6 month courses
- *Plan to use UNICEF training plan for TBA program

1988

First quarter

- *Established a Maternal-Child Health room as part of Al-Jehad Outpatient Department; health education programs given in waiting areas
- *47 students began 3 month course; course extensively revised
- *Afghan physician hired as first training doctor
- *Curriculum development coordinator hired
- *Developed improved plan for conducting monitoring of health facilities inside Afghanistan
- *2 female staff identified to work in TBA program; sent to Bannu, Pakistan for practical experience
- *14 women in Kandahar selected for TBA training, but only 2 arrived in Quetta and both found to be unsuitable candidates
- *TBA course postponed because lack of a suitable midwife trainer
- *Conducted ongoing inservice training for hospital nurses

- *Developed "walking" blood bank established
- *Surgical facilities upgraded, surgical program increased

Second quarter

- *Anesthesia machine purchased, laboratory procedures expanded to include diagnostic tests for typhoid
- *First aid course re-established as 2 month course
- *First aid course VI ended, 15/24 graduates went to Afghanistan; a total of 95 students trained over previous 12 months
- *First aid course VII started, using revised curriculum
- *Total of 95 first aid students trained
- *AMA course III continued, with emphasis on practical experience; a total of 56 trained over previous 12 months
- *Outside instructors brought in to teach some specific topics, such as guest lecturer from UNICEF taught students about ORS
- *Course instruction limited to list of approved medicines
- *Continued attempts to recruit women from Kandahar for training; unsuccessful
- *Also, unsuccessful in identifying qualified midwife to teach course
- *Recruited 2 expatriate nurses, 1 doctor, and 1 laboratory technician to assist with the training
- *Upgraded Al-Jehad to a surgical training facility

Third quarter

- *Restructured AMA course to include 3 months of general training and 3 months of specialty training
- *Wound dressing techniques upgraded by nursing inservices
- *Vaccinators sent to Quetta EPI office for mini-refresher
- *X-ray machine set up at Al-Jehad
- *Health workers from IAHC Medical Training Course and OHI physical therapy course observed at Al-Jehad
- *Developed cooperative referral arrangements between Al-Jehad and other medical facilities in Quetta
- *First aid course VII concluded; 15/22 graduates returned to Afghanistan
- *New selection process for First aid course VIII initiated; much more rigorous
- *Re-evaluated AMA course; developed curriculum using 3 months of academic work, and 3 months of practical experience
- *X-ray technician hired for Al-Jehad
- *Problems with previous plan for cooperative introduction of prospective students through MSH and AHC; AHC withdrew because MCI instructors found to be "politically unacceptable". Revised plan to bring workers staffing MCI-administered clinics for training
- *Curriculum developed for women's course and appropriate clinical MCH facilities established

67

Fourth quarter

*Established Medical Review Board to oversee medical practices at Al-Jehad Hospital

*As fighting intensity in Afghanistan decreased, reordered focus of 3 month First Aid Course from emergency treatment of wounded to a broader "Basic Health Worker" Course

*First aid course VIII concluded; 15/18 students returned to Afghanistan

*First aid course IX delayed because of elections in Pakistan

*AMA course curriculum very successful: requested for use by ICRC, MSH, UNHCR, CMC, IMC, AICF, LEPCO, IAHC, and Health Unlimited

*AMA course translation completed (Dari, Pushto, English)

*Field assessment of former students reveals that insufficient OPD training given; thus course modified to enhance OPD experience

*Plan to re-train all AMA students from 1st and 2nd courses in refresher course using new curriculum

1989**First quarter**

*14 students complete First aid course IX (now termed BHW course)

*Recruited two new expatriate volunteers for dentistry and radiology

*In previous 12 months, a total of 213 BHW trained, 154 working in Afghanistan, and 94 AMA students trained, 76 working in Afghanistan

*Developed new record-keeping system for OPD

*AMA students attended TB hospital for specialty rotation

*Students began to see female patients during OPD rotations

*Head surgeon resigned

Third quarter

*BHW course X concluded with 19 students

*AMA course IV graduated 25 students, 23 returned to Afghanistan

*AMA course V began with 31 students

*Both courses lengthened because of increase in field work: for example, BHWs visited local refugee camps to observe sanitation, water supplies, etc.

*Completed the "Common Disease Manual and Formulary" for the AMA course

*2 Afghan training staff attended Training of Trainers workshop in Peshawar (SCF)

*Nurse from MCI Baghran facility attended Program Manager's Course in Peshawar (SCF)

*Afghan nurse hired for MCH, 3 Afghan doctors hired for training staff

*BHW students participated in mine awareness program

*Planned for TB control program in Baghran

Fourth quarter

- *First Outreach Workers graduated
- *24 BHW students graduated; 30 enrolled in new course

1990

First quarter

- *MCI students began training in manufacturing prostheses in cooperation with OHI
- *Computerized Al-Jehad ward paperwork
- *Leprosy Mission conducted inservice for OPD doctors, nurses, and training staff
- *Dental curriculum reviewed
- *BHW course graduated 22 students
- *AMA V graduated 30 students; new course began with 12 months curriculum (6 month basic, 3 month OPD, 3 month specialty)
- *Began pilot project on TB control at Baghran Hospital
- *Agreement with other NGOs to standardize lab and dental curricula

Second quarter

- *Hospital staff now comprised of 14 Afghan doctors (2 surgeons, 2 anesthesiologists, 5 training doctors, 3 MCH physicians, and 2 male OPD doctors)
- *Nurses attended mine awareness program
- *Lab skills forms finalized and lab manual revised
- *Use of videos in training activities begun
- *Final BHW course began
- *Collaborative agreement with OHI to train 4 students and operate Baghran clinic for prostheses
- *AMA courses have trained a total of 149 students, 86% working in Afghanistan; BHW courses have trained a total of 295 students, 68% working in Afghanistan
- *Nurse Pari, an experienced midwife, staffed the MCH department

Third quarter

- *Moved MCH activities to a separate facility
- *Instituted concept that all medical staff were part of training staff
- *Ongoing delays in establishment of medical ward
- *Dental department held internal refresher course for technicians
- *Developed plans for cost recovery for surgical service at Al-Jehad Hospital
- *AMA students visited local refugee camp to observe MSF sanitation project
- *Course for prosthetic workers completed; graduates moved to Baghran

Fourth quarter

- *Recruited students for AMA VII
- *Began new course for prosthetics workers
- *Two physicians working at MCI clinics inside Afghanistan returned to Quetta for refresher visit
- *Began to track the number of medicines dispensed per patient
- *10-bed medical ward opened
- *5-bed female surgical ward opened
- *Dr. Amanallah appointed as head of training
- *Began discussions with many other NGOs about refresher training

1991**First quarter**

- *Core group meetings continued in Peshawar to plan CMCEP course
- *Curriculum manual on cardiology was prepared and translated
- *AMA VI concluded with 27 students, AMA VIII began with 28 students
- *Two doctors from MCI clinics in Ghazni and Kandahar each spent one month in Quetta for refresher visit
- *All MCH clinic workers were trained in water sanitation and parasite prevention

Second quarter

- *Developed 3 month MCH assistant training curriculum; started first course
- *10 female health worker students selected; only 6 allowed to come by families
- *Phased out orthopedic activities at Al-Jehad
- *Established separate training division, distinct from "inside" activities
- *Completed one year of sole management of Al-Jehad Hospital
- *Established separate facility for MCH Clinic - the only MCH Clinic in Quetta for Afghan refugees
- *Screening evaluation of CMCEP candidate-students
- *Inservice for Al-Jehad nurses on first aid and basic nursing skills
- *AMA VI students graduated, returned to posts in Afghanistan
- *Enrolled 5 students in MCH assistant course
- *AMA students rotated through MCH clinic to develop familiarity with medical problems of children and women
- *CDD workshop (Control of Diarrheal Diseases) held by WHO, UNICEF and MCI; attended by 15 physicians including 4 MCI training doctors
- *10 students (including 5 MCI students sponsored by USAID) completed prosthetic training with OHI and began work at prosthetic workshop in Baghran
- *Established fee-for-service for MCH and surgical services
- *Established women's surgical ward at Al-Jehad, and 10 bed

medical ward

*ORT corner started at MCH

*WHO visiting experts conducted workshops in ORT and nutritional education

Third quarter

*USAID suspended all support for medical services inside Afghanistan

*Began first Combined Mid-Level Continuing Education Program (CMCEP) refresher training

*Appointed an Afghan woman physician the Head of MCH Clinic

*Completed 3 month MCH assistant course with 5 students; all awaited placement in Afghanistan because of security concerns

*Added staff nursery at MCH clinic to encourage breast feeding return to work by female staff

*Started nutrition corner at MCH

Fourth quarter

*First CMCEP course concluded

*Completed preparation of MCH training manual in English, continued Dari and Pushto translations

*Fee-for-service initiated for inpatient treatment and at MCH Clinic for non-essential labwork; some nurses reassigned as clerks to assist in revenue generating activities

*Core Group meetings continued in Peshawar and Quetta

*Training doctors attended seminar at Barouri Hospital TB treatment center

1992

First quarter

*USAID lifted suspension of medical activities inside Afghanistan

*Final AMA course VII concluded; 27/28 students went to Afghanistan

*6 surgical beds at Al-Jehad transferred to medical ward; contagious disease ward started

*CMCEP II began

*Core Group meetings continued

*16 Training instructors, including MCH workers, attended 5 day TOT session in Quetta arranged by CMCEP and SCF

*Staff continued visits to Barouri Hospital TB treatment center for refresher

*Developed cooperative arrangement for x-ray services with Al-Khidmat hospital

*MCH assistant manual Pushto and Dari translations completed

*2 vaccinators attended refresher course in Peshawar

*TBA program began in refugee camps near Quetta (non-USAID funded)

*Arrangements with Aga Khan Hospital to send nurses and technicians for 1 month training and refresher

*12 wk review course of anatomy and physiology for Al-Jehad

male nurses

- *Developed on-call system at Al-Jehad
- *Transferred 6 surgical beds to medical beds, established contagious diseases ward
- *Core group meetings continued
- *First trained MCH assistant began work at Khakraiz clinic; others await placement due to security and travel problems
- *24 health workers from surgery section dismissed

Second quarter

- *All surgical activities at Al-Jehad discontinued
- *Sent first of a series of training staff to Aga Khan Hospital in Karachi for observation and refresher training
- *CMCEP II graduated 20 students, CMCEP III students arrived
- *Core Group meetings continued
- *Female MCH-O (Maternal Child Health Officer) training begun, but suspended in accordance with USAID advisory to standardize course
- *MCH-O curriculum meetings initiated
- *MCH assistant course II begun with 7 students
- *English lessons offered to staff at Al-Jehad
- *3 trained MCH assistants assigned to Malestan clinic but poor security conditions prevented their placement

Third quarter

- *CMCEP III began with 19 students; students participate in "on-call" activities with training doctors
- *Core Group meetings continued
- *3 staff nurses and 3 laboratory technicians each spent 1 month at Aga Khan Hospital in Karachi
- *Field Microscopist curriculum meetings initiated
- *15 MCI training staff participated in TOT workshop in Quetta for 1 week
- *6 students complete MCH assistant course; all await placement but poor security continues
- *Female doctors included on morning rounds on hospitalized patients
- *Weekly teaching conference begun for training doctors
- *2 vaccinators to AVICEN for refresher
- *Inpatient activity at Al-Jehad limited

Fourth quarter

- *Dr. Imam appointed Health Division Head
- *Al-Jehad closed December 10 in accordance with directive from USAID
- *MCH Clinic closed December 30 in accordance with directive from USAID
- *Core Group meetings continued
- *Field Microscopist Refresher Course planned

1993**First quarter**

- *Inventoried all material from Al-Jehad hospital
- *Moved training material to Mirwais Hospital in Kandahar
- *Completed selection of students for CMCEP IV

Second quarter

- *Postponed CMCEP IV because of serious fighting in Kandahar; training staff was evacuated to Quetta
- *Notified by USAID of discontinuation of all funds for medical programs; prepared phase-out plans

Third quarter

- *Restarted CMCEP IV course in Kandahar, concluded it in Boldak for security reasons
- *Mirwais hospital further damaged, and most of training material ruined or stolen

Fourth quarter

- *Concluded all USAID funded medical activities in Pakistan and Afghanistan

ANNEX 5OUTLINE OF COURSE CURRICULA

- A. Basic health worker
- B. Transitional public health worker
- C. Mid-level health worker
- D. Out-reach worker
- E. Maternal Child Assistant
- F. Mid-level health worker refresher course (Combined mid-level continuing education program [CMCEP])

ANNEX 5A

OUTLINE OF BASIC HEALTH WORKER CURRICULUM

ANNEX 5A**Outline of BHW curriculum****THREE MONTH TRAINING COURSE**

Total hours: 432 (6 hours/day, 6 days/week, 12 weeks)
 Instructors: Doctors for theory and practicals; one
 English/Math instructor
 Students: 24-30 per course

Statement of Educational Purpose:

The 3 month training program is for the purpose of training village level health workers. These workers will be working independently in their village, but will be connected to and supervised by a nearby OPD facility. They will have the ability to encourage the general population in basic health care and to perform basic first aid to war-wounded and those that are sick.

General Objective:

The overall objective of the 3 month training course is to provide Mujahadeen returning to Afghanistan with sufficient skills to safely perform basic life-saving first aid measures, and to adequately provide basic health teaching and care regarding simple health problems and public health.

Specific Objectives:

1. Each student will be able to understand the aspects of anatomy and physiology that specifically relate to practical care.
2. Each student will develop a knowledge of and ability to perform:
 - a. basic life-saving first aid measures
 - b. health teaching regarding preventive health and health problems
 - c. safe use of medicines
 - d. basic nursing skills/techniques (i.e. vital signs, wound care and dressings, sterilization techniques, injections)

Teaching method and materials:

1. Teaching will be done through lectures, demonstrations, return demonstrations, practice and discussions.
2. Practical work will be done at Al-Jehad Hospital and OPD.
3. Testing of skills and knowledge will be done through practical examination, written or oral exams.
 - a. Exams will be held once a week and/or at the end of the subject area.
 - b. A final practical exam will be given for first aid, and final written exam for other subjects.
4. Teaching materials:
 - a. Lecture notes
 - b. Equipment supplies necessary for first aid

- c. Life-size doll/mannequin
- d. Visual aids (anatomy charts etc.)
- e. Medical equipment/supplies necessary for leaning basic nursing skills/techniques

Basic Daily Schedule:

- 9:30-10:30 English
- 10:30-11:30 Math (alternated with practical in OPD clinic when scheduled)
- 11:30-12:30 Lecture
- 12:30- 1:30 Lunch/Prayer break
- 1:30- 4:30 Practical (first aid, nursing skills)

RESPONSIBILITIES/DUTIES OF A VILLAGE LEVEL HEALTH WORKER

1. Safely perform basic life-saving first aid measures for the mujahadeen and civilian population.
2. Give health teaching regarding preventive health and simple health problems taught in this course.
3. Safely treat the simple health problems with the medicines taught in this course.
4. Treat the war-wounded or sick by safely performing basic nursing skills taught in this course.
5. Because the first aid worker works independently in the field, he is responsible to know the limitations of his knowledge and abilities to treat serious injuries or illnesses, and to transfer or refer these cases to another facility.
6. Keep proper and accurate records of patients seen, diagnoses and treatments given, plus other reporting required by Al-Jehad Hospital.
7. Respect the rights, values and dignity of all patients.

7

3 month training course outline

I. Introduction to course

1. Explanation of course - objectives/purpose
 - a. expectation of students
 - b. responsibilities/duties of a village level health worker
2. Overview of course
 - a. class schedule
 - b. course outline

II. Basic Anatomy and Physiology

1. Overview/introduction
2. Respiratory system
3. Circulatory system
4. Skeletal system
5. Muscular system
6. Eye/Ear
7. Digestive system
8. Urinary system
9. Skin
10. Nervous system

III. First Aid

1. Introduction:
 - a. What is first aid?
 - b. First Aid care
2. Assessment of trauma (examining sick/injured person)
3. Blocked airway - open airway/breathing procedure
4. Care of the unconscious patient
5. Control of bleeding
6. Control of shock
7. Wounds (scrapes, lacerations, bullet wounds)
8. Bandaging
9. Bone and joint injuries - fractures
 - dislocations
 - sprains
 - strains (muscle injuries)
 - a. Immobilizing and splinting
10. Transporting an injured patient
11. Trauma to the eye
12. Trauma to the head
13. Trauma to the chest
14. Trauma to the abdomen
15. Trauma to the spinal cord
16. Burns (including chemical burns)
17. Poisonings
18. Hypothermia/Frostbite
19. Heat exhaustion/heat cramps/ heat stroke
20. Animal and human bites
21. Snake bites

22. Insect bites/anaphylactic shock
23. Foreign bodies in the ear
24. Mass casualties and injuries - Triage

IV. Nursing Skills/Techniques

1. Vital signs (temperature, pulse, respiration)
2. Injections (intramuscular, subcutaneous, intradermal)
3. Application of hot and cold
4. Asepsis/sterilization
 - a. Cleaning and sterilization techniques
 - b. Preparation and use of antiseptic/disinfectant solutions
 - c. Hand-washing
 - d. Asepsis and sterile technique
 - e. Opening a dressing change kit
 - f. Dressing of wounds
5. Wound care management
 - I.
 - a. Wounds and wound healing
 - b. Complications of wound healing
 - II.
 - a. Initial care
 - b. Wound inspection
 - c. Clean/infected wounds
 - d. Wound irrigation
 - e. Dressings

V. Simple Health Problems

1. Common cold
2. Influenza
3. Sore Throat
4. Anemia
5. All body pain
6. Stress Headache
7. Back pain
8. Sciatica
9. Strains/Sprains
10. Conjunctivitis
11. Dry eyes
12. Toothache
13. Malnutrition
14. Diarrhea
15. Dehydration
16. Worms
17. Heartburn
18. Constipation
19. Skin problems
20. Scabies
21. Malaria

VI. Pharmacology

1. Safe use and abuse of medications
2. Medication names

3. Routes of administration
4. Indications, contraindications and side effects
5. Dosage, frequency and duration
6. Review of each drug given to the student

ANTISEPTICS:

1. Methyl Alcohol 1 liter bottle
2. Soap bar
3. Gentian Violet crystals 4.5mg/500ml=1% soln.
4. Savlon 1 liter
5. Potassium permanganate crystals

DIGESTIVE SYSTEM:

1. Ferrous Sulphate/folic acid tablets
2. Multivitamin tablets
3. Multivitamin drops bottle
4. Mebendazol (Vermox) tablets
5. Magnesium trisilicate 500mg tablets
6. ORS 1 liter packets (20 packets per box)

ANALGESIC AND ANTIPYRETIC

1. Paracetamol syrup 60ml
2. Paracetamol 500mg tablets
3. Acetylsalicylic acid (Asprin) 300mg tablets

EYE-EAR-SKIN:

1. Tetracycline eye ointment
2. Chloramphenicol eye drops
3. Benzyl benzoate 25% 60ml bottle
4. Vaseline 400 gm
5. Menthylated balm (Iodex or Algipan)
6. Antibacterial cream (Furacin)
7. Glycerin (emollient for derm) 60cc bottle

ANTIMALARIAL:

1. Chloroquine 250mg tablets
2. Chloroquine syrup 60ml

MISCELLANEOUS:

1. DDT powder (box)

VII. Math Review

1. Addition, subtraction, multiplication, division
2. Fractions, decimal places, percentages
3. Volumes, weights
4. Metric measures
5. Graphs
7. Dosage calculations

VIII. Preventive Health

1. What is preventive health - introduction
2. Personal/Family cleanliness

3. Community cleanliness
4. Food sanitation
5. Safe water supplies
6. Safe disposal of feces
7. Safe rubbish disposal
8. Insect and rodent control
9. Good nutrition
10. Immunity and vaccination
11. Health teaching
12. Preparation and teaching of ORS

IX. English

1. Simple English reading and writing
2. Necessary anatomical and medical words
3. Calendar and dates
4. Drug names and reading doses, expiration dates, etc.
(some basic English is necessary for health workers in Afghanistan as medicines have English labels)

X. Responsibilities of a village level health worker inside Afghanistan

1. Responsibilities/duties to be performed
2. Referral system of patients needing higher level of care
3. Record keeping

ANNEX 5B

OUTLINE OF TRANSITIONAL PUBLIC HEALTH WORKER

CURRICULUM

ANNEX 5B**Outline of Transitional Public Health Worker Curriculum****TRANSITIONAL BHW TRAINING COURSE**

Total hours: 197 (6 hours/day, 5 days/week, 8 weeks)
Instructors: Doctors/Nurse for theory and practical; one
English instructor
Students: 24 per course

Statement of Educational Purpose:

This transitional BHW course is for the purpose of training village level health workers. These workers will be working independently in their villages, but will have the capacity to work closely with health care facilities in their areas and transfer or refer patients to these facilities. They will have the ability to encourage the general population in primary health care and to perform basic first aid to wounded and those that are sick.

General Objectives:

The overall objective of this training course is to provide Mujahideen returning to Afghanistan with sufficient skills to safely perform life-saving first aid measures, and to adequately provide basic health teaching and care regarding public health.

Specific objectives:

1. Each student will develop a knowledge of and ability to perform:
 - a. Basic life-saving first aid measures
 - b. Health teaching regarding preventive health and health problems.
 - c. Basic Nursing skills/techniques (i.e. vital signs, wound care and dressings, sterilization techniques).

Teaching methods and materials:

1. Teaching will be done through lectures, demonstrations, return demonstrations, practice and discussions.
2. Practical work will be done at Al-Jehad Hospital and OPD.
3. Testing of skills and knowledge will be done through practical examination, written or oral exams.
 - a. Exams will be held at the end of the subject area.
 - b. A final practical exam will be given for first aid, and final written exam for other subjects.
4. Teaching materials:

- a. lecture notes
- b. Equipment supplies necessary for first aid
- c. Life-size doll/mannequin
- d. Visual aids (anatomy charts etc.)
- e. Medical equipment/supplies necessary for learning basic nursing skills/techniques.

Basic Daily Schedule:

09:30 - 10:30 English
10:30 - 11:30 Lecture (alternated with practical in OPD clinic when scheduled)
11:30 - 12:30 Lecture
12:30 - 01:30 Lunch/Prayer break
01:30 - 04:30 Practical (first aid, nursing skills)

RESPONSIBILITIES/DUTIES OF A VILLAGE LEVEL HEALTH WORKER

1. Safely perform basic life-saving first aid measures for the mujahadeen and civilian population.
2. Give health teaching regarding preventive health and public health problems taught in this course.
3. Treat the war-wounded or sick by safely performing basic nursing skills taught in this course.
4. Because the village level health worker works independently in the field, he is responsible to know the limitations of his knowledge and abilities to treat various injuries or illnesses, and to transfer or refer these cases to another facility.
5. Respect the rights, values and dignity of all patients.

TRANSITIONAL BHW TRAINING COURSE OUTLINE

I. Introduction to course

1. Explanation of course - objectives/purpose
 - a. Expectation of students
 - b. Responsibilities/ duties of a village level health worker
2. Overview of course
 - a. Class schedule
 - b. Course outline

II. First Aid

1. Introduction:
 - a. What is first aid?
 - b. First Aid care
2. Assessment of trauma (examining sick/injured person)
3. Blocked airway - open airway/breathing procedure
4. Care of the unconscious patient
5. Control of bleeding
6. Control of shock
7. Wounds (scrapes, lacerations, bullet wounds)
8. Bandaging
9. bone and joint injuries
 - fractures
 - dislocations
 - sprains
 - strains (muscle injuries)
 - a. Immobilizing and splinting
10. Transporting an injured patient
11. Trauma to the eye
12. Trauma to the head
13. Trauma to the chest
14. Trauma to the abdomen
15. Trauma to the spinal cord
16. Burns (including chemical burns)
17. Poisoning
18. Hypothermia/Frostbite
19. Heat exhaustion/heat cramps/heat stroke
20. Animal and human bites
21. Snake bites
22. Insect bites/anaphylactic shock
23. Foreign bodies in the ear
24. Mass casualties and injuries - Triage

III. Nursing skills/Techniques

1. Vital signs (pulse, respiration)
(Basic Anatomy and Physiology for respiration/circulation)
2. Application of hot and cold
3. Asepsis/sterilization
 - a. Cleaning and sterilization techniques
 - b. Preparation and use of antiseptic/disinfectant solutions
 - c. Hand-washing

f.c.
u

- d. Asepsis and sterile technique
 - e. Opening a dressing change kit
 - f. Dressing of wounds
- 4. Wound care management
 - I. a. Wounds and wound healing
 - b. Complications of wound healing
 - II. a. Initial care
 - b. Wound inspection
 - c. Clean infected wounds
 - d. Wound irrigation
 - e. Dressings

IV. Preventive Health

- 1. What is preventive health - introduction
- 2. Personal/family cleanliness
- 3. Community cleanliness
- 4. Food sanitation
- 5. Safe water supplies
- 6. Safe disposal of feces
- 7. Safe rubbish disposal
- 8. Insect and rodent control
- 9. Good nutrition
- 10. Immunity and vaccination
- 11. Health teaching

V. English

- 1. Simple English reading and writing
- 2. Necessary anatomical and medical words
- 3. Calendar and dates

VI. Responsibilities of a village level health worker in Afghanistan

- 1. Responsibilities/duties to be performed
- 2. Referral system of patients needing higher level of care
- 3. Record keeping

HOURS OF TEACHING BY SUBJECT

INTRODUCTION & RESPONSIBILITIES	2
LEARNING, TEACHING & EXAMS	4
NURSING SKILLS	38
PREVENTIVE HEALTH	12
FIRST AID	107
ENGLISH	34
	197 total hours

ANNEX 5C

OUTLINE OF ADVANCED MEDICAL ASSISTANT CURRICULUM

ANNEX 5COutline of Advanced Medical Assistant CurriculumMCI 6 MONTHS ASSISTANT HEALTH WORKER TRAINING COURSEObjective:

The objective of this 6 month training course is to recruit students from inside Afghanistan (preferably with first aid or medical experience), give them an additional six month of specialized training, and send them back in teams to staff clinics or hospitals supported by MCI, in the Southwest region of Afghanistan.

The southwest provinces from which the students will be selected are:

Zabul	Nimroz
Kandahar	Ghorat
Rozgan	Herat
Helmand	Badghis
Farah	Ghazni (western half)

Training Program:

Because the training needs differ for students working in hospital areas from those working in an OPD, the course is divided into sections:

- I. Basic education training course (for all students) (3 months)
- II. Specialty area training rotation (3 months)
 1. OPD
 2. Dental/Dispensary
 3. Laboratory
 4. Operating theater
 5. Hospital ward nursing
 6. X-ray

In each 6 month course given, the necessity for all these rotations will vary according to the needs for hospital, OPD-A or OPD-B students being trained during that specific course.

Our program requires that a group of students from one area are pre-tested, selected and trained with the specific purpose of going back inside as a group to work in either a hospital or OPD setting. MCI's project goals dictate which specialty rotation will be offered during a given course.

The number of students necessary for a hospital or OPD are:

<u>Hospital</u>	<u>OPD-A</u>	<u>OPD-B</u>
1 Laboratory	1 Laboratory	1 OPD
1 Dental/Dispensary	1 Dental/Dispensary	1 Dental/Dispensary
1 OPD	1 OPD	1 Operating theater
1 X-ray		
3 Hospital ward nursing		

~8 students	3 students	2 students

The students are trained to be assistant health workers and WILL NOT be working independently.

Each hospital will have a qualified doctor in charge of the graduated students.

Each OPD will have a qualified nurse in charge of the graduated students.

6 MONTH COURSE CURRICULUM

I. BASIC EDUCATION COURSE (all students)

<u>Theory/Practical content:</u>	<u>Total Hours:</u>
1. Orientation to 6 month course	2
2. English	30
3. Math	38
4. General Pharmacology and Formulary	44
5. Anatomy and Physiology	39
6. Biology Review	4
7. First Aid	93
8. Nursing Skills	134
9. Learning and Teaching / Taking exam	3
10. Preventive Health	12
11. Common disease and treatment	119
12. History taking and Physical exam	50
13. Orientation to Specialty Rotation	2

	570 hours

II. SPECIALTY ROTATIONS

1. Laboratory
 2. Dental/Dispensary
 3. Operation theater
 4. Hospital ward nursing
 5. X-ray
 6. OPD (Outpatient clinic worker)
-

I. BASIC COURSE OUTLINES

A. First Aid

1. Introduction:
 - a. What is first aid?
 - b. First Aid care
2. Assessment of trauma (examining sick/injured person)
3. Blocked airway - open airway/breathing procedure
4. Care of the unconscious patient
5. Control of bleeding
6. Control of shock
7. Wounds (scrapes, lacerations, bullet wound)
8. Bandaging
9. Bone and joint injuries
 - Fractures
 - Dislocations
 - Sprains
 - Strains (muscle injuries)
- a. Immobilizing and splinting
10. Transporting and injured patient
11. Trauma to the eye
12. Trauma to the head

13. Trauma to the chest
14. Trauma to abdomen
15. Trauma to spinal cord
16. Burns (including chemical burns)
17. Poisonings
18. Hypothermia/Frostbite
19. Heat exhaustion/heat cramps/heat stroke
20. Animal and human bites
21. Snake bites
22. Insect bites/anaphylactic shock
23. Foreign bodies in the ear
24. Mass casualties and injuries - Triage

B. Nursing Skills/Knowledge

1. Vital signs (temperature, pulse, respiration, blood pressure)
2. Fever
3. Asepsis - sterilization
 - a. Cleaning and sterilization techniques
 - b. Use and preparation of antiseptic/disinfectant solutions
 - c. Handwashing
 - d. Asepsis/sterile technique
 - e. Use of gloves
 - f. Opening of sterile kit
 - g. Dressing of wounds
4. Wound care management
 - I.
 - a. Wounds/wound healing
 - b. Complications of wounds
 - II. Wound care
 - a. Initial care
 - b. Wound Inspection
 - c. Clean/infected wounds
 - d. Wound irrigation
 - e. Dressings
 - f. Bullet wounds
 - g. Debridement
 - h. Suturing
 - i. Use of xylocaine
 - j. Treatment of abscess
5. Injections (intramuscular, subcutaneous, intradermal)
6. Intravenous infusion (technique, solutions, drip rates)
7. Ear examination/use of otoscope
8. Ear care (syringing, foreign body removal, instillation of ear meds)
9. Dehydration - recognition and treatment
10. Preparation of ORS
11. Health teaching
12. Ethics, Nursing and Understanding Illness
13. Local application of heat and cold
14. Urinary catheter insertion
15. Nasogastric tube insertion

16. Eye care (including application of eye meds and removal of foreign body)

17. Weighing (adult/child), Road to health charts
18. POP (application, positioning, complications, removal)
19. Fracture care
20. Collection of lab specimens, lab values
21. Record keeping (green books)
22. Cleaning of OPD

C. Math

1. Roman Numerals
2. Addition, subtraction, multiplication, division
3. Common fractions, decimal fractions
4. Measuring and reading syringes
5. Percentages and graphs (solutions and xylocaine)
6. Weights and measures (metric, apothecary and units)
7. Calculation of dosages
 - a. Adult/child
 - b. Dosage by Kg body weight
 - c. Pure drug in syrup and suspension
 - d. Dosage for specific duration

D. English

1. Simple English reading and writing
2. Necessary anatomical and medical words
3. Calendar and dates
4. Drug names and reading doses, expiration dates, etc.
(Some English is necessary for health workers in Afghanistan as medicines have English labels)

E. Basic Pharmacology

1. Definitions
2. Uses of pharmacology
3. Medicine names
4. How are medicines given
5. When should medicine not be given
6. Don'ts in preparing and giving drugs
7. Drug indications and contraindications and side effects
8. Dose of medicine
9. Timing of administration
10. Duration in giving the medicine
11. Mode of action of different drugs
12. Antibiotics
13. Abbreviations

F. Preventive Health

1. What is preventive health-introduction
2. Personal/family cleanliness
3. Community cleanliness
4. Food sanitation
5. Safe water supplies
6. Safe disposal of feces

7. Safe rubbish disposal
8. Insect and rodent control
9. Good nutrition
10. Immunity and vaccinations
11. Health Teaching
12. Preparation and teaching of ORS

G. Common diseases and treatment

1. Eye
2. Ear, nose, throat
3. Mouth
4. Respiratory
5. Cardiovascular
6. Gastrointestinal
7. Genitourinary
8. OB/GYN
9. Fever without obvious source
10. Neuro-psychiatric
11. Musculoskeletal
12. Skin
13. Nutritional diseases
14. Pediatrics
15. Drug Formulary

H. Basic anatomy and physiology

1. Overview, introduction
2. Respiratory system
3. Circulatory system
4. Skeletal system
5. Muscular system
6. Eye, ear
7. Digestive system
8. Urinary system
9. Skin
10. Nervous system
11. Endocrine
12. Reproductive system

Specialty Rotation Course Outlines

OPD Training Course Outline

1. Introduction to course

- a. Explanation of course - objectives
 - i. Expectation of students
 - ii. Responsibilities/duties of OPD assistants
- b. Overview of course
 - i. Class schedule
 - ii. Course schedule

2. OPD Skills

- a. Record keeping -green books/clinic register
- b. History taking
- c. Physical examination
- d. History and physical examination of infants and children
- e. Terminology
- f. Setting up and maintaining OPD

3. Review of skills and techniques

- a. Vital signs
- b. Weighing/Road to Health Chart
- c. Dehydration/ORS
- d. Asepsis-sterilization-practical application
 - i. Asepsis
 - ii. Hand-washing
 - iii. Sterilization techniques (formol tablets, boiling)
 - iv. Sterile technique
 - v. Use of gloves
 - vi. Use and preparation fo antiseptic/disinfectant solutions (savlon, gentian violet, etc.)
- e. Wound care and management -practical application
 - i. Initial care
 - ii. Dirty/clean wounds
 - iii. Debridement
 - iv. Dressing changes
 - v. Simple suturing (removal of sutures and drains)
 - vi. Use of xylocaine
- f. Injections (IM, SC, ID)
- g. Intravenous infusion (technique, solutions, rates)
- h. Nasogastric tube insertion
- i. Eye care (application of meds, foreign body removal)
- j. Ear care (application of meds, foreign body removal)
- k. POP (application, position, complication, removal)
- l. Fracture care (splinting, traction)
- m. Collection of specimens for lab
- n. Lab values

4. Common diseases and treatments

5. Formulary

X-ray Rotation Course Outline

1. X-ray photography and darkroom
 - a. The x-ray film-how it is made, care of films
 - b. Screens and cassettes-parts of a screen and cassette, care of screens and cassettes
 - c. Developing an x-ray- processing by hand
 - i. chemicals: developer, fixer, rinse
 - ii. how to develop a film
 - d. Care of the darkroom
2. X-ray images
 - a. What is an x-ray
 - b. How is an x-ray produced
 - c. Things that effect the appearance of the x-ray
 - i. contrast
 - ii. sharpness
 - iii.enlargement
3. Protection against the harmful effects of x-ray
 - a. Effects of radiation -introduction
 - b. Protection of x-ray workers
 - c. Protection of patients
 - d. Care of equipment used for protection
4. Care of the patients
 - a. General care of equipment - cleanliness
 - b. Preparation of patients for x-ray examination (normal, special)
5. Positions for x-ray examination
 - a. Basic positions
 - b. Limiting the beam
6. Marking the film

Ward Nursing Course Outline

1. Introduction to the course curriculum
2. Review
 - a. Nursing ethics
 - b. Qualities of a good nurse
3. Documentation
4. Body mechanics and bed making
5. Personal hygiene
 - a. Bed bath
 - b. Oral care
 - c. Back care

- d. Passive range of motion
- 6. Review TPR
 - a. Chest auscultation
- 7. Intake and output
- 8. Review of sterile technique
- 9. Review of urinary catheterization
 - a. Bladder irrigation
- 10. Enemas: rectal tube
- 11. Review of collection of specimens
- 12. Review of local application of heat and cold
 - a. Tepid sponging
 - b. Sitz bath
- 13. Decubiti care
- 14. Review nutrition: importance of nutrition in hospitalized patient
- 15. Review wound care
 - a. Dressing changes
 - b. Bandaging
- 16. Review medications
 - a. P.O.
 - b. I.M.
 - c. I.D.
 - d. Eye/ear
 - e. Al-Jehad's PRN medications
 - f. Al-Jehad's Emergency Protocol
- 17. Review: Intravenous insertion/removal/complications
- 18. Review: Nasogastric Tubes
- 19. Pre-op care
- 20. Post-op care
 - a. Review
 - b. Shock
 - c. Hemorrhage
- 21. General nursing care for a patient with plaster of paris
- 22. General post-op care of the orthopedic patient

23. Care of unconscious patient
24. Patient admission/discharge
25. Cleaning the ward
26. Discussion: setting up the hospital ward

Operating Theater Rotation Course Outline

1. Operating Theater Team
2. Expected behavior of OT personnel
3. Medical record
 - a. Admission
 - b. Informed consent
 - c. Discharge
4. Patient education
5. Presurgical preparation
 - a. Preparing the patient from his room
 - b. Pre-anesthetic medication
 - c. Transporting the patient to the OT
6. Organizing the OT
 - a. Before the first operation of the day
 - b. Before each operation
7. Surgical instruments
8. Disinfection/antiseptis/autoclaving
9. Scrubbing
10. How to: cap, mask, glove [closed and open techniques], gloving another person, gown, gowning another person
11. Opening sterile supplies
12. Skin preparation
13. Draping
14. Aseptic principles during surgery
15. Maintaining a sterile field
16. Wounds, wound care, dressings
17. Debridement

18. Suturing/ suture removal
19. Sponge, sharps, and instrument counts
20. Intraoperative notes
21. Recovery room assessment- immediate post-operative period
22. Post-operative care- tracheal suction, pressure sores
23. Post-operative complications
24. CPR: adults, children
25. Patient instructions postoperative discharge
26. IV therapy: butterfly, plastic catheter
 - a. Complications of IV therapy
 - b. Discontinuing IV infusion
27. Indwelling catheters
 - a. Insertion
 - b. Daily care
 - c. Removal
28. Cast
 - a. Application
 - b. Removal
29. Assisting the anesthesiologist

Laboratory Course Outline

1. Registrar
 - a. How to properly design a registrar book
 - i. Urine
 - ii. Stool
 - iii. Hematology
 - iv. Sputum AFB
 - b. How to give proper instructions for specimen collection
 - i. Urine for U/A
 - ii. Urine for pregnancy
 - iii. Stool for parasites
 - iv. Blood
 - v. Sputum for AFB
2. Slide preparation
 - a. Sputum AFB
 - b. Thick blood film
 - c. Thin blood film
 - d. Urine sediment

- e. Stool
3. Staining procedures
 - a. Leishman stain
 - b. Giemsa stain
 - c. Ziehl-Nielsson
 4. Blood collection
 - a. Fingerstick
 - b. Venipuncture
 5. Hematology
 - a. Hgb
 - i. Pipetting with Sahli pipette
 - ii. Reading hemoglobinometer
 - iii. Recording the results
 - b. WBC count
 - i. Pipetting with graduated and Sahli pipette
 - ii. Filling of Neubauer Chamber
 - iii. Counting of WBC in Neubauer Chamber
 - iv. Calculating the WBC from dilution
 - v. Recording the results
 - c. ESR
 - i. Pipetting with graduated pipette
 - ii. Filling of ESR pipette
 - iii. Reading ESR pipette
 - iv. Recording of results
 6. Malaria
 - a. Identification of parasites
 - i. *P. vivax*
 - ii. *P. falciparum*
 - b. Identification of stage of parasites
 - i. Trophozoite
 - ii. Schizont
 - iii. Gametocyte
 - c. Quantification of parasitemia
 - d. Recording the results
 7. Parasitology/Stool
 - a. Distinguish between hard, soft, liquid
 - b. Recognize the colors brown, black, green, red
 - c. Recognize blood and mucus
 - d. Recognize proglottids
 - e. Recognize and quantify
 - i. *Taenia* spp
 - ii. *Hymenolepis nana*
 - iii. *Ascaris lumbricoides*
 - iv. *Trichuris trichuria*
 - v. *Enterobius vermicularis*
 - vi. Hookworm
 - vii. *Strongyloides stercoralis*

- viii. Entamoeba histolytica
 - ix. Entamoeba coli
 - x. Chilomastix mesneli
 - xi. Giardia lamblia
 - xii. Trichomonas spp
 - xiii. RBC/WBC
- f. Distinguish between trophozoite and cysts
- g. Distinguish between bacterial and amoebic dysentery
8. Sputum AFB: identification and quantification
9. Urine
- a. Proper reading of multistix-SG
 - b. Use of urinometer
 - c. Recognition and quantification
 - i. WBC
 - ii. RBC
 - iii. Epithelial cells
 - iv. Casts (WBC, RBC, Hyaline, Granular, Bacteria, Trichomonas)
 - v. Crystals (calcium oxalate, uric acid, triple phosphate)
 - vi. Amorphous sediment
 - vii. Spermatozoa
 - viii. Yeast
 - d. Able to correlate urine chemistry with microscopic exam
10. Microscopy
- a. How to properly care for microscope
 - i. transport
 - ii. cleaning
 - iii. storage
 - b. How to correctly focus microscope
 - c. How to adjust light using condenser and mirror
 - i. low power
 - ii. high power
 - iii. oil
 - d. How to distinguish size of objects using ocular micrometer

Dental Course Outline

Part I:

- 1. Anatomy
 - a. Tooth
 - b. Gingiva
- 2. Oral physiology- saliva
- 3. Dental plaque
- 4. Dental disease
 - a. caries

- b. periodontal disease
- 5. Preventive dentistry
 - a. Plaque control
 - b. Oral hygiene
 - c. Toothbrushing techniques
 - d. Dental health education
 - e. Prevention of periodontal disease
 - f. Diet
 - g. Scaling and polishing
 - h. Scaling instrumentation

Part II:

1. Head and neck anatomy
2. Sterilization
3. Diagnosis and treatment planning
4. Extraction of teeth
5. Incision and suturing
6. Drainage of abscess
7. Filling of small cavities
8. Local anesthesia
9. Drugs in dentistry
10. Dental instruments
11. Dental emergencies
12. Dental x-rays

Dispensary Course Outline

Part I:

1. Organizing medicines in the dispensary room
2. Care of the dispensary room
3. Care of medications
4. The drug container and the storage of drugs
5. Rules of administering medicines
6. Routes of drug administration
7. Reasons to consider when administering drugs
8. Drug interactions
9. Side effects
10. Toxic reactions
11. Drug metabolism and excretion
12. Drugs and pregnancy
13. Drugs and lactation
14. Drug therapy in children
15. Drug therapy in the elderly
16. Prescription writing and reading
17. Giving instructions to the patient
18. Abbreviations
19. Table of equivalents

Part II:

Review of drug formulary
(list available upon request)

ANNEX 5D

OUTLINE OF OUTREACH WORKER COURSE CURRICULUM

ANNEX 5D**Outline of Outreach Worker Course Curriculum****OUTREACH WORKER TRAINING COURSE**

- Total time:** 303 hours Classroom theory/practical
(6-7 hours/day, 6 days/week, 8 weeks)
4 weeks Field practical experience in refugee camps
- Instructors:** 3 AICF Master Trainers; Al-Jehad doctors and nurse
- Students:** 15 per course

Statement of Educational Purpose:

This Outreach Worker Course is for the purpose of training village level health workers (Outreach Workers), with their main focus being Primary Health Care (PHC), thereby beginning the introduction of a primary health care component into the present MCI Medical Program's health facility/worker system inside Afghanistan. These Outreach Workers (ORW) will be attached to and supervised by MCI's medical facilities inside. They will have the ability to encourage the general population in primary health care and to perform basic first aid to wounded and those that are sick.

General Objectives:

The overall objective of this course is to provide mujahadeen returning to Afghanistan with sufficient skills and knowledge to perform his role in health promotion and disease prevention in his village community, and safely perform basic life-saving first aid measures.

Specific Objectives:

1. Each ORW student will develop a knowledge of and ability to perform:
 - a. Health promotion and disease prevention through health education, case-finding and follow-up (for TB and Malaria), in collaboration with the MCI "curative" staff
 - b. Basic life-saving first aid measures
 - c. Basic nursing skills/techniques (i.e. wound care and dressings, sterilization techniques and injections)
 - d. Selection and training of Community Health Workers (in the future when and where possible)
 - e. Preparation of slides after properly collecting samples

- for AFB and Malaria slides
- f. General health education to the community regarding: prevention of disease, simple treatments (such as ORS solution for diarrhea and dehydration), hygiene, nutrition, sanitation, rehydration and vaccination

Teaching Method and Materials:

1. Teaching will be done through lectures, demonstrations, return demonstrations, practice, group discussions and role playing.
2. Theory and practical work will be done at Al-Jehad Hospital/OPD.
3. Field practical work will be done at the refugee camps.
4. Testing of skills and knowledge will be done through practical exams and written or oral examination.
5. Teaching materials:
 - a. Lecture notes
 - b. Equipment supplies necessary for first aid
 - c. Life-size doll/mannequin
 - d. Medical equipment/supplies necessary for learning basic nursing skills/techniques and preparation of ORS
 - e. Specific teaching material (from SCF-UK) such as "The Chain of Contamination", "TB Prevention", "Hygiene"
 - f. Flip charts from UNICEF and UNHCR
 - g. Other visual aids (whiteboard, overhead projector, filmstrips).

Basic Daily Schedule:

08:30 - 01:00 ORW program
 01:00 - 02:00 Lunch/prayer
 02:00 - 04:15 First aid nursing skills

Alternate with

08:30 - 12:00 FA/Nursing skills
 12:00 - 01:15 Lunch/prayer
 01:15 - 05:50 ORW program

4 Weeks: Living at BHU in camps, working with ORWs, and in laboratory for field practical experience (follows ORW work/time schedule)

JOB DESCRIPTION FOR OUTREACH WORKER INSIDE AFGHANISTAN

Position titles: Outreach Worker (ORW)

Responsible to :

1. Medical in-charge of the hospital/clinic inside
2. Outreach Worker Supervisor

Duties and Responsibilities:

1. ORW will be attached to the hospital/clinic and will act as the link between the clinic and the village community. He should be in continuous contact and liaise with the Medical In-charge of the clinic, the group leaders in the community (and with the health committee, if one exists).
2. The ORW is responsible for his specific village(s). Preferably, he has been selected from this village, and is known by the community there. His main goal will be the promotion of health and prevention of disease in his village community.
 - a. The out reach worker is responsible to teach his knowledge to the community and the Community Health Worker (CHW) (when present in the health system) regarding the prevailing health programs, their prevention and control measures.
3. Main duties and responsibilities in the village community:
 - a. Prevention and control of TB: case detection, sputum collection, follow-up, supervision of treatment, health education.
 - b. Prevention and control of malaria: case detection, taking of blood slides, follow-up, health education and helping with malaria spray programs (when available).
 - c. Sanitation: health education regarding latrines, wells, breeding places for mosquitos (water collection and drainage) and flies (garbage, refuse, night soil) safe drinking water and take necessary action accordingly.
 - e. When an immunization program is available in his area, he's responsible for motivation of the community regarding the importance of immunization, what diseases can be prevented, and methods of health education regarding the above.
 - f. General Health Education to the community: regarding prevention of disease, simple treatments (such as sugar-salt ORS solution for dehydration and diarrhoea);

hygiene, nutrition, sanitation, rehydration, vaccination.

- g. Dealing with health/illness emergencies in the community (giving first aid when necessary) and referring patients/victims to the hospital/clinics; to treat minor health problems and do dressings in cases of wounds and burns.
4. Duties and responsibilities at the hospital/clinic: Depending on his time/work schedule in the community distance from the clinic.
 - a. Teaching ORS to diarrhoeal/dehydration patients and their attendants.
 - b. Assisting with dressing changes when needed.
 - c. Preparing sputum and malaria slide lists and sending to laboratory, and maintaining all necessary records and reports.
 5. In the future, selection and training of community Health Workers from their village community, and supporting and supervising the CHWs after training.
 6. Specific Duties regarding Tuberculosis Control and Prevention
 1. Recognition of patient with TB, referring to a hospital/clinic, and collection of sputum.
 2. Preparing AFB slides for transport to clinic/hospital.
 3. Recording of specimens in lab recordbooks/sheets.
 4. Knowledge regarding and follow-up for both negative and positive AFB results.
 5. For TB cases;
 - a. Recognition of TB medicines and their side effects.
 - b. Importance of compliance and method of ensuring thereof.
 - c. Recording compliance over full treatment period.
 - d. What to do in the event of non-compliance; when to refer.
 - e. Health Education.
 - f. Advise and monitoring of contacts.
 - g. Infection technique for streptomycin, possible problems.
 6. Community Education.
 7. Specific Duties regarding Malaria Control and Prevention
 1. Recognition of patient with malaria and collection of thick and thin smears, and referral to hospital/clinic.
 2. Preparation and recording of slides for transport to

- hospital/clinic.
3. Knowledge regarding follow-up of negative and positive results.
 4. Post-treatment follow-up.
 5. Supervise and keep records of any antimalarial spray programs done in their village community.

OUTREACH WORKER TRAINING COURSE OUTLINE

I. Introduction to course

1. Explanation of course - objectives purpose
 - a. expectation of students
 - b. Responsibilities/duties of an Outreach Worker.
2. Overview of course
 - a. class schedule
 - b. course outline

II. Outreach Worker Program Outline

1. Introduction
 - a. What is Primary Health Care (PHC) - 8 elements, aims, needs
 - b. Role of the Out Reach Worker, Job Description
2. Microbes
 - a. Pathological way of infection
 - b. Feco/oral spread
3. Sanitation

a. clean water	d. VIP latrines
b. wells	e. compost latrines
c. sand filters	f. preparation of food
4. Methodology

a. discussion	c. lecture
b. skills	d. role of the teacher
5. Diarrhea and dehydration
 - a. Introduction
 - b. ORS - practical preparation and role play
6. Fever and cold sponging
7. Malaria
 - a. lecture
 - b. role play
8. Methodology
 - a. Role play - details of role play
 - b. Practical skills: How to wash the hands

9. Respiratory diseases
 - a. common cold
 - b. sinusitis
 - c. tonsillitis
 - d. bronchitis
 - e. pneumonia
 - f. causal chain
10. Tuberculosis
 - a. TB cases
 - b. sputum
 - c. spread of TB
 - d. dangers
 - e. prevention
 - f. TB medicines demonstration
 - g. observation of a TB patient
11. Methodology
 - a. questions and answers
 - b. communication skills
 - c. visual aids
 - d. evaluation techniques
12. Revision/review
13. Vaccination
 - a. Introduction
 - b. Measles
 - c. Whooping Cough
 - d. Diphtheria
 - e. Tetanus
 - f. Polio
 - g. The vaccination card
 - h. Motivation of the people
14. Eye and ear diseases
 - a. Eye infections/prevention
 - b. Eye injuries and prevention
 - c. Cleaning the eye
 - d. Instilling eye medicines
 - e. Ear infections/prevention
 - f. Cleaning the ears
15. Revision/review
16. First Aid review
 - a. Airway/breathing
 - b. Bleeding control
 - c. Control of shock
 - d. Splinting
 - e. Prevention of accidents
 - f. Poisoning/prevention
 - g. Burns
 - h. Bite
 - i. Heat stroke
17. Nutrition
 - a. 4 food groups
 - b. Soft food for children
 - c. Role play - food preparation
18. Malnutrition
 - a. Marasmus
 - b. Kwashiorkor
 - c. Arm circumference
 - d. Growth cards
19. Pregnancy and children
20. Revisions/review

21. Anemia and worms
22. Use and misuse of medicines
23. Home visits - role play
24. Follow -up and referral system
25. Mine awareness program (theory and practical)
26. Revision/review
27. Reporting system - growth work
28. The Outreach Worker Kit - advises
29. Exam preparation (students/teachers)
 - a. Personal review/revisions for the students
30. Written Outreach Worker examination
31. Practical Outreach Worker examination
32. Correction of exams and finalizing marks
33. Practical field work at the Basic Health Units (BHUs)
 - a. Two to four weeks at the camps (Surkhab or Piralizia)
 - b. I: Work in the laboratory - collection and preparation of malaria smears and AFB slides
 - c. II: Work with the ORW of the BHU, both in the BHU and the field
34. Graduation.

III. First Aid

1. Introduction:
 - a. What is first aid?
 - b. First Aid care
2. Assessment of Trauma (examining sick/injured person)
3. Blocked airway - open airway/breathing procedure
4. Care of the unconscious patient
5. Control of bleeding
6. Control of shock
7. Wounds (scrapes, lacerations, bullet wounds)
8. Bandaging
9. Bone and joint injuries - fractures
 - dislocations
 - sprains
 - strains (muscle injuries)
 - a. Immobilizing and splinting
10. Transporting an injured patient
11. Trauma to the eye
12. Trauma to the head
13. Trauma to the chest
14. Trauma to the abdomen
15. Trauma to the spinal cord
16. Burns (including chemical burns)
17. Poisoning
18. Hypothermia/Frostbite
19. Heat exhaustion/heat cramps/heat stroke
20. Animal and human bites
21. Snake bites

22. Insect bites/anaphylactic shock
23. Foreign bodies in the ear
24. Mass casualties and injuries - Triage

IV. Nursing skills/Techniques

1. Asepsis/sterilization
 - a. Cleaning and sterilization techniques
 - b. Preparation and use of antiseptic/disinfectant solutions
 - c. Hand washing
 - d. Asepsis and sterile technique
 - e. Opening a dressing change kit
 - f. Dressing of wounds
2. Wound care management
 - I.
 - a. Wounds and wound healing
 - b. Complications of wound healing
 - II.
 - a. Initial care
 - b. Wound inspection
 - c. Clean/infected wounds
 - d. Wound irrigation
 - e. Dressings
3. Injections (intramuscular, subcutaneous, intradermal)
 - a. Mixing a vial of powdered medicine for injection

V. Responsibilities of an Outreach Worker Inside Afghanistan

1. Review of responsibilities and duties to be performed
2. Integration of Outreach Workers and PHC into the curative/medical "health care system" available inside Afghanistan
3. Relationship to other health care workers in health care facility to which the ORW will be attached
4. Responsibilities of MCI - rules and regulations for an MCI employee.

ANNEX 5E

MATERNAL CHILD HEALTH ASSISTANTS COURSE CURRICULUM

MATERNAL CHILD HEALTH ASSISTANTS COURSE CURRICULUM

1. Introduction
 - schedule
 - teaching methods
 - practical experience
 - practical examination
 - unit exams (written)
 - requirements for graduation
 - terms of placement after graduation
 - introduction to MCH health services
2. Basic A & P (22 hrs)
3. Basic Nursing skills (40 hrs)
 - handwashing 1 hr
 - vital signs 1 hr
 - microbes, cleaning, and sterilizing (3 hr)
 - use of gloves (1 hr)
 - dressings (3 hr)
 - fever (1 hr)
 - injections (SC, IM, ID, IV - 16 hrs)
 - ear exam (1 hr)
 - dehydration (2 hr)
 - ORS (1 hr)
 - application of heat and cold (1 hr)
 - catheterization (2 hr)
 - eye care (1 hr)
 - cleaning the OPD (1 hr)
4. Sanitation and general hygiene (4 hr)
 - personal hygiene (1 hr)
 - clean water (1 hr)
 - safe food (1 hr)
 - management of the home (1 hr)
5. Infant growth and nutrition (2 hr)
 - introduction to nutrition (2 hr)
 - nutritional guidelines for various ages (1 hr)
 - breastfeeding (2 hr)
 - weaning foods (2 hr)
 - growth monitoring (2 hr)
 - malnutrition in children (1 hr)
 - preparation and use of NG (1 hr)
 - nutritional deficiencies (1 hr)
6. The physical exam (7 hr)
 - introduction to the physical
 - method for the physical

- lab investigations
 - eyes, ears, nose, and throat
 - lungs and abdomen
 - breast exam
 - exam of the child
7. EPI (7 hr)
 - the five diseases we vaccinate against
 - the vaccination schedule and method for each vaccine
 - the cold chain
 - patient and community education
 8. Gynecology (3 hr)
 - vaginal discharge, vaginal infection
 - pelvic infection
 - dysmenorrhea, abnormal vaginal bleeding
 9. Pregnancy and prenatal care (10 hr)
 - signs and symptoms of pregnancy
 - normal problems of pregnancy
 - dangerous problems in pregnancy
 - the pregnancy exam
 - teaching in pregnancy
 - abortion, threatened abortion, incomplete abortion
 10. Labor and delivery (7 hr)
 - first stage of labour and supportive care
 - second stage of labour and nursing care
 - third stage of labour and nursing care
 - dangers in the first stage of labor
 - dangers in the second stage of labor
 - dangers in the third stage of labor
 - care of the baby at birth and cutting of the cord
 11. Postpartum care
 - care of the baby after birth
 - care of the mother after birth
 - normal body changes after birth
 - normal post-partum care
 - problems after delivery: postpartum hemorrhage, infection, mastitis, breast abscess
 12. Child spacing (2 hr)
 13. Patient education (3 hr)
 - importance of education
 - methods of education, use of teaching cards

ANNEX 5F

MID-LEVEL HEALTH WORKER REFRESHER COURSE

(Combined Mid-level Continuing Education Course)

ANNEX 5FMid-level Health Worker Refresher Course Curriculum
(Combined Mid-level Continuing Education Course)

Combined Midlevel Continuing Education Course Outline

I. Primary Health Care/MCH

A. Primary Health Care: introduction

1. Health care problems in Afghanistan

-Group discussion

-Lecture

-morbidity and mortality in Afghanistan with special focus on women and children

-safe motherhood

-major causes of death among women

-safe motherhood strategies

-child survival

-major causes of death among children

-child survival strategies

-the link between maternal and child health

-major root causes of death

-Video: "We can get there from here" Safe motherhood initiative, South Asia

2. Introduction to the PHC concept

a. Definition of PHC

-equal distribution of health

-community participation

-multisectorial collaboration

-appropriate technology

-cost-effective at the national level

b. Elements and strategies of PHC

c. PHC infrastructure in Afghanistan

d. The health pyramid

-reintegration of the pyramid

-Mid-level health workers's role within the pyramid

e. Traditional medical care vs. PHC

3. PHC Circle

a. Health education

b. Nutrition

c. Immunization

d. MCH, including family planning

e. Water and sanitation

f. Control of endemic diseases

g. Treatment of common diseases

h. Provision of essential drugs

B. Health Education

1. Definition, strategies, principles, and means in health

116

education

- a. Introduction
- b. Objectives
- c. Means
- d. Target group
2. Planning health education activities
 - a. Information collection and identifying needs
 - b. Preparing a teaching plan including health education campaign
 - c. Deciding teaching method
 - d. Deciding teaching aids
 - e. Preparation of teaching aids
3. Implementation and evaluation of health education
 - a. Practical sessions role-playing
4. Community participation and involvement: theory and techniques
5. The importance of role models: discussion
6. Identification of scope of health education activities
 - a. practical skills development in PHC areas
7. Visit the community for practical experience

C. Nutrition

1. General concept of nutrition
2. Assessment of community/cultural factors affecting nutrition
 - a. Nutritional resources in the community
 - locally available foods and nutritional substitutes
 - b. Beliefs relating to nutrition which positively or negatively affect nutritional status
 - hot/cold
 - other taboos
 - c. Identify problems of undernutrition and etiology
 - poor use of available food
 - lack of food
 - nutrition during illness
 - delayed introduction of foods during weaning
 - nutritional risk groups
3. Nutrition data collection and reporting
 - a. Obtaining nutritional information from patient/family
4. Growth and development of a healthy infant/child
 - a. Nutritional needs
 - b. Growth monitoring (Road to Health)
5. Childhood malnutrition
 - a. Recognition/prevention/treatment/health education
 - marasmus
 - kwashiokor
 - b. Screening using MUAC (measure and record all children 1-5 yrs in community)
 - c. Correct use of MUAC tape

- d. Make tape from locally available materials
- e. Record information
- f. Teach parent meaning of measurements and advise
- 6. Identify, prevent, treat, health education re:
 - a. Anemia
 - b. Goiter
 - c. Vitamin A deficiency
 - d. Measles
 - e. GI disturbances, especially vomiting, diarrhea, dehydration
- 7. Nutrition education
 - a. Breast feeding - no bottles
 - b. Weaning practices
 - c. Dietary needs of pregnant and lactating women
 - d. Making and use of ORS
 - e. Preparation of super-porridge
 - f. Appropriate feeding during illness and health
- D. Immunization
 - 1. Immunity
 - 2. Target population
 - 3. Target diseases
 - measles, tetanus, polio, diphtheria, pertussis, TB
 - 4. Vaccines
 - 5. Record keeping
 - 6. Community education
- E. Maternal Child Health
 - 1. Maternal Health
 - a. Working with TBAs
 - demonstrate TBA's essential lessons on handwashing, sterile deliveries, ORT
 - demonstrate expansion of messages which can be taught to TBAs
 - supply of TBAs
 - b. Pregnancy: prenatal care
 - diet
 - prevention/treatment of anemia
 - importance of prenatal care
 - drug avoidance during pregnancy
 - teach men in family care of women during pregnancy
 - personal hygiene
 - preparation for delivery
 - c. Normal pregnancy
 - slight edema
 - urinary frequency
 - constipation
 - morning sickness
 - breast tenderness/swelling
 - d. Abnormal pregnancy
 - severe edema
 - bleeding
 - bleeding with fever

- incomplete abortion
- complete abortion
- e. Diseases with increased risk in pregnancy
 - malaria, UTI, anemia, pre-eclampsia, early labor
- f. Delivery
 1. Normal delivery
 - recognize symptoms of labor
 - refer to trained personnel if possible
 2. Abnormal delivery
 - hemorrhage
 - use of methergine, IV fluids for postpartum hemorrhage
 - direct uterine massage
 - transfer/refer
 - early ruptured membranes/signs of infection
 - ruptured uterus: signs/symptoms/refer
- g. Postpartum
 1. Normal postpartum physiological, psychological
 2. Abnormal problems
 - hemorrhage/infection
 3. Health education
 - promote/advise breast feeding
 - advise dietary fluid needs for breast feeding
 - teach importance of colostrum
 - post-episiotomy care
- h. Women's care (child spacing on request)
 1. Menstrual cycle
 - normal, abnormal bleeding, dysmenorrhea
 2. Vaginal disorders
 - candidiasis, trichomonas, bacterial infections, vaginitis
 3. Infertility
 4. Child spacing (on request)

2. Child Health

- a. Newborn care
 - normal newborn characteristics
 - care of newborn
 - advice on immunization
 - advice on cord care
 - diet: breast feeding, no bottles, use of cup and spoon
 - recognize/teach physiological jaundice; refer if persistent
 - hygiene
 - swaddling
 - advice on body temperature maintenance
- b. Diseases problems of newborn
 - congenital anomalies
 - fever: look for s/s meningitis, pneumonia, sepsis

- neonatal tetanus
- neonatal conjunctivitis
- simple cord infection
- diaper rash

3. Pediatrics

- a. Normal healthy child
- b. Diseases of children
 - measles (and complications), chickenpox,
 - pertussis, tetanus, malnutrition, meningitis,
 - scarlet fever, rubeola, convulsions (febrile and other), polio, mumps, TB, diphtheria, complications of EPI diseases, congenital anomalies (identify/refer)

F. Environmental Health (Water and Sanitation)

1. Water
 - Assessment of community practices and problems
 - Waterborne diseases -identify risk factors
 - source, use, safety, hygiene, storage, purification
 - Community education
2. Waste product disposal
 - Health problems caused by unsafe waste disposal
 - Assessment of community practices/problems re: waste disposal
 - Methods for proper waste disposal
 - Community education
3. Accident prevention
 - safety at home
 - cooking fires/burns, poisons/drugs storage, gun safety, others
 - mine awareness
4. Personal hygiene
 - personal body cleanliness, handwashing, clean clothes, food handling, rest and recreation
 - community habits: spitting, tobacco/naswar, toilets
 - community education regarding hygiene

G. Control of endemic diseases

1. Vector control: insects, rodents, community education

H. Treatment of common diseases

J. Provision of essential drugs

II. Common diseases diagnosis and treatment

- A. Dermatology: impetigo, scabies, abscess, cellulitis, candidiasis, dermatophytosis
- B. Eye: viral and bacterial conjunctivitis, trachoma, eye trauma, foreign body removal, corneal ulceration, decreased

visual acuity, glaucoma

C. ENT: common cold, otitis media and externa, perforated tympanic membrane, chronic otitis, viral and bacterial tonsillitis, sinusitis acute and chronic, mastoiditis, epistaxis, diphtheria, croup/epiglottitis, impacted cerumen, thrush/oral candida, foreign body

D. Respiratory: cough, allergy, bronchitis, pneumonia, asthma, TB, anaphylaxis

E. Cardiovascular: hypertension, acute rheumatic fever, hemorrhoids, chest pain- angina pectoris, myocardial infarction, congestive heart failure

F. Gastrointestinal: Differential diagnosis re types of diarrhea (viral, parasitic, bacterial dysentery, food poisoning); dehydration, ORS, worms, gastritis, acute abdomen, cholecystitis, GI bleeding, teaching and prevention

G. Genitourinary: UTI, renal colic, urinary retention

H. Infectious diseases: malaria, meningitis, septicemia, chickenpox, typhoid, cholera, hepatitis, rabies

I. Musculoskeletal: good body mechanics, sprains/strains, back pain, arthritis, osteomyelitis, common fractures, common dislocations

J. Neuropsychiatry: Neurological conditions/problems (headache, convulsions, sciatica, coma), Psychiatric conditions (anxiety, agitation, depression)

III. Nursing and Clinical Skills

A. Patient assessment

1. History and physical exam
2. Vital signs (TPR, BP)
3. Otoscope

B. Administration of drugs

1. Review of pharmacology
2. Adults and children
3. Application of oral/topical drugs
4. Injections and proper sites (IM, ID, SQ)
5. Intravenous administration
 - start, management, discontinue
 - management of complications

C. Basic wound care

1. clean technique
2. Sterile technique
3. Handling equipment, instruments, materials
 - sterilization, care of equipment, handling sterile material
4. Infection control: handwashing, skin preparation, putting on sterile gloves, proper disposal of contaminated material and fluids, isolation techniques
5. Application of dressings
6. Simple infected wounds
7. Abscess
8. Surgical debridement of wounds
9. Local anesthesia

10. Burns: identification and treatment

- D. Eye, ear irrigation
- E. NG tube insertion, Urinary catheter insertion
- F. Application of heat/cold
- G. Health system/management skills
 - data collection, clinic management (facility, personnel), supplies, equipment
 - home visiting, community outreach
 - coordination of services

IV. First aid

- A. Airway, breathing, circulation
- B. Hemostasis
- C. Shock
- D. Immobilization of injury
- E. Primary treatment of fractures/dislocations
- F. Basic trauma care
- G. Transport of injured

ANNEX 6

MCI Rules and Regulations for Students in Training

126

ANNEX 6**MCI Rules and Regulations for Students in Training****ENTRANCE REQUIREMENTS (for AMA course)**

1. The candidate should be an Afghan and should be recommended to the program by one of the seven main Afghan political parties.
2. The candidate should not be less than 20 years of age.
3. The candidate should undergo a general physical checkup and should not be suffering from any communicable diseases or other sicknesses which might disrupt his studies.
4. The candidate should have had formal education at the level of 3-month first aid training and should show a valid certificate. Also, at least one year of active field experience is needed.
5. If a candidate and his immediate family have migrated outside of Afghanistan, they will not be considered for admission to the program.
6. After meeting the above requirements, the candidate must sit for and pass the pre-arranged entrance exam set by the curriculum committee.

STUDENT RESPONSIBILITIES IN THE COURSE

1. Every student is responsible for attending all classes and lectures fully and regularly.
2. No disruption of any kind during the lecture and class hours is allowed. Any person who commits such an act will be punished accordingly.
3. Every student has to devote all his time to studying. No political activity is allowed during the course period.
4. Every student is to inform the administration of any sickness through the pre-arranged official system.
5. Students should only stay in the dormitory of prescribed hospital during their sickness. Students are not allowed to stay any other place.
6. It is the student's responsibility to contact instructors upon his immediate return after an absence.
7. Lateness or absence to one lecture is considered absence for the whole day.
8. Absence from an exam means 0% unless the student is officially ill or granted permission to leave due to an emergency.
9. Any absence registered for even one hour is to be punished by the loss of the stipend for the whole day.
10. If any student has problems in understanding his studies, he should immediately contact the related teacher for help. If the teacher fails to solve the problem, then he can complain to the curriculum committee through the administrator of the dorm.
11. In choosing the right profession for the students, the decision of the curriculum committee is final. The student does not have any right to object to it.

12. If a student behaves improperly towards a teacher, the teacher can report him to the curriculum committee and the curriculum committee can put him on probation. If the student continues his improper behavior he can be dismissed or temporarily suspended by the curriculum committee.
13. All the students are obliged to follow the directions of the administrator of the dormitory, unless these directions go against the spirit of this script.
14. Every student can submit his logical and legal complaints against the teaching and administrative staff of the course in writing through the curriculum committee's complaint box. If the student feels that his complaint was not given attention, then the complaint must be officially submitted to the director of education and training of MCI for immediate consideration.
15. Students will be required to sign a written contract with MCI.

STUDENT RESPONSIBILITIES IN THE DORMITORY

1. The administrator of the dorm is to allocate the rooms and combination of the students in the dorm.
2. Every student is required to be in the dorm when there is no teaching or classes.
3. Each student is responsible for the protection and cleanliness of the dorm and its equipment. Students cannot take dorm furniture and equipment outside the dorm.
4. Meals are arranged by the administrator of the dorm only. If any student has complaints, he can register them with the administrator of the dorm.
5. Students must not behave improperly with the dorm employees. Any misconduct should be reported to the administrator of the dorm.
6. Students cannot bring their friends and relatives to their rooms. They can receive them only in the common reception area.
7. Alcoholic, toxic, and dangerous drugs and materials are not allowed in the dorm.
8. No weapon of any kind is allowed in the dorm.
9. Students can only use official holidays for visiting friends outside the dorm. Prior to any departure, the student should report his probable absence and address to the administrator.
10. Each student is expected to practice religious activities according to his belief and should not be allowed to cause insult or disrespect to the rituals and beliefs of other students. Violation of this principle is irresponsible and such a person is considered unfit to further serve mankind.
11. No student is allowed to humiliate or disturb the calm and peace of other colleagues. Such behavior is punishable by probation or even dismissal.
12. Violence, fights, or provocation of other students to such improper behavior is punished with immediate dismissal if proven upon investigation.
13. The immediate authorities for solving all problems in

administration and education are the dorm administrator and curriculum committee respectively.

EDUCATIONAL AND ADMINISTRATIVE AUTHORITIES

DEFINITIONS AND RESPONSIBILITIES

1. The director of education is the head of the curriculum committee (all teaching staff are members of the curriculum committee), and is directly responsible to the program manager of MCI.
2. The administrator of the dorm is directly responsible to the director of education. The director of education will bring matters needing attention to the appropriate department. The curriculum committee is responsible for all matters pertaining to education, curriculum, or students. The accounting section is responsible for all matters pertaining to administration, finance, or daily running of the dorm.
3. The responsibilities of the Administrator:
 - smooth running of the dorm
 - coordinate dorm's activities with education schedule
 - recommend appointment or removal of any personnel to the curriculum committee for final approval by MCI program manager
 - report any irregularity in the dorm to the director of education or the head of MCI
 - regulate the behavior of each student and report any irregularity to the authorities mentioned above in writing
 - regulate attendance of teaching and administrative staff and individual students, and submit official reports at regular intervals to the director of education
 - provide meals and other daily requirements of the students according to pre-set standards
 - arrange night-duty list from among the students and establish a report of the previous night's events each morning
 - prepare a list of stipends for the students according to their attendance and send it to the director of education for inspection and final action by the accounting section by the 29th of each month
 - prepare all documents and papers in regard to regular expenditures of the dorm and send them to the accounting section for action
 - arrange documentation for all the furniture and equipment of the dorm and establish responsibility for them among individuals in each section
 - general and direct supervision of the cleanliness of all sections of dorm and grounds
 - keep the biographic cards of each student updated until the end of the educational period, and officially submit these complete cards to the director of education after the departure of the students

MISCELLANEOUS

-each student is allowed 1 day leave per month besides official holidays. Leave must be pre-arranged with the dorm administrator and notice sent to teachers before leaving. Leave cannot be granted on the day of an examination.

-each teacher must have a special educational record notebook. The achievements and attendance of each student should be kept during each session. Any absence should be reported to the dorm's administrator immediately

-the decisions of the curriculum committee are registered in a special minutes book, and if necessary, can be sent to the dorm administrator through the educational director for perusal by the students and staff members

-all official documents of the dorm for MCI should be signed by the director of the dorm or his assistant if the director is absent

GRADING SYSTEM GUIDELINES (available upon request)

1. Schedule of examinations
2. Frequency of examinations
3. Individual course grading
4. Final program grade

ATTENDANCE AND TARDINESS REGULATIONS (available upon request)**PROCEDURES FOR ILLNESS (available upon request)**

ANNEX 7

GEOGRAPHIC DISTRIBUTION OF MCI-ADMINISTERED HEALTH
CENTERS

7A: ACTIVE MCI CLINICS PER PROVINCE PER YEAR

7B: MAPS

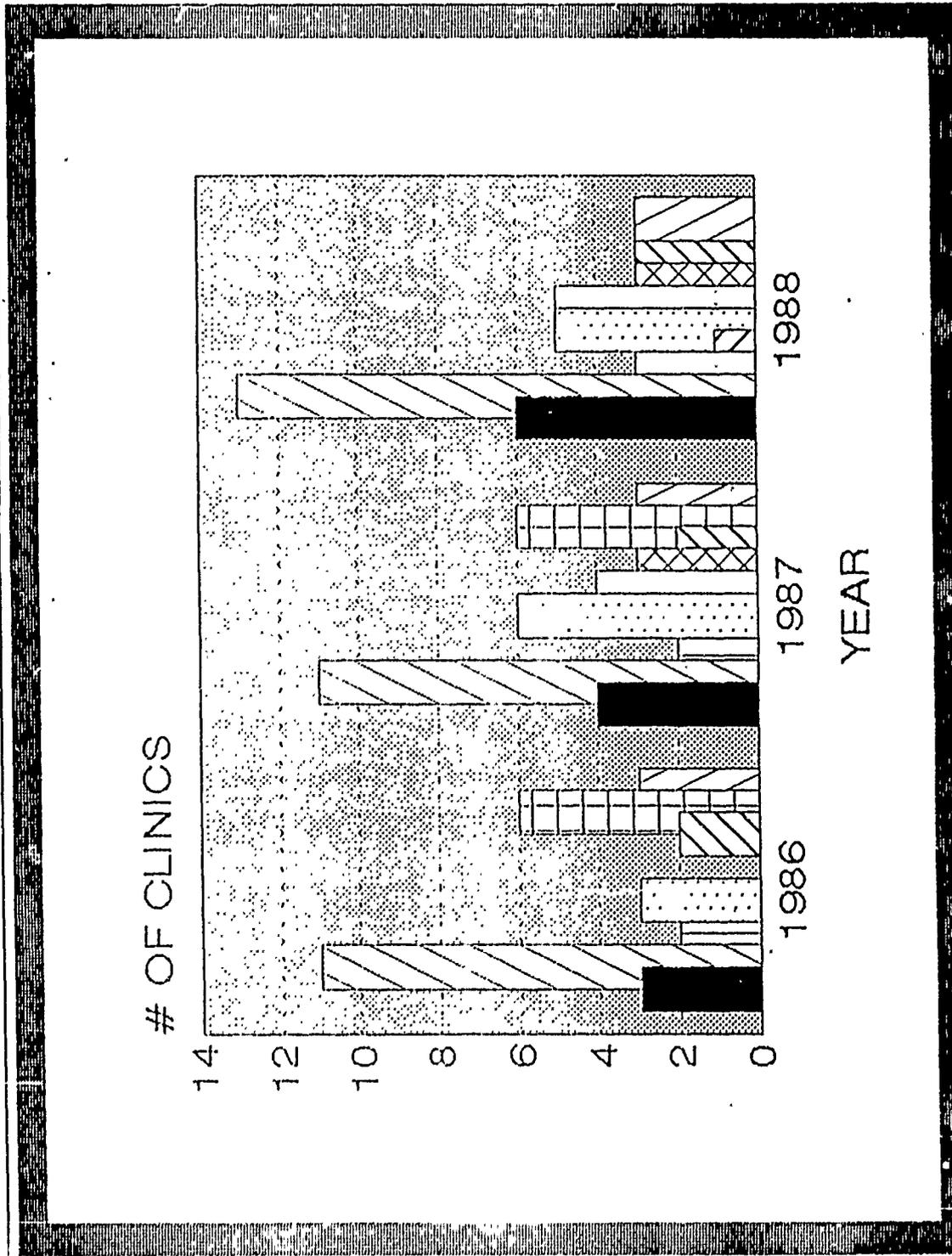
7C: MCI CLINICS LEVEL BREAKDOWN PER YEAR

ANNEX 7A

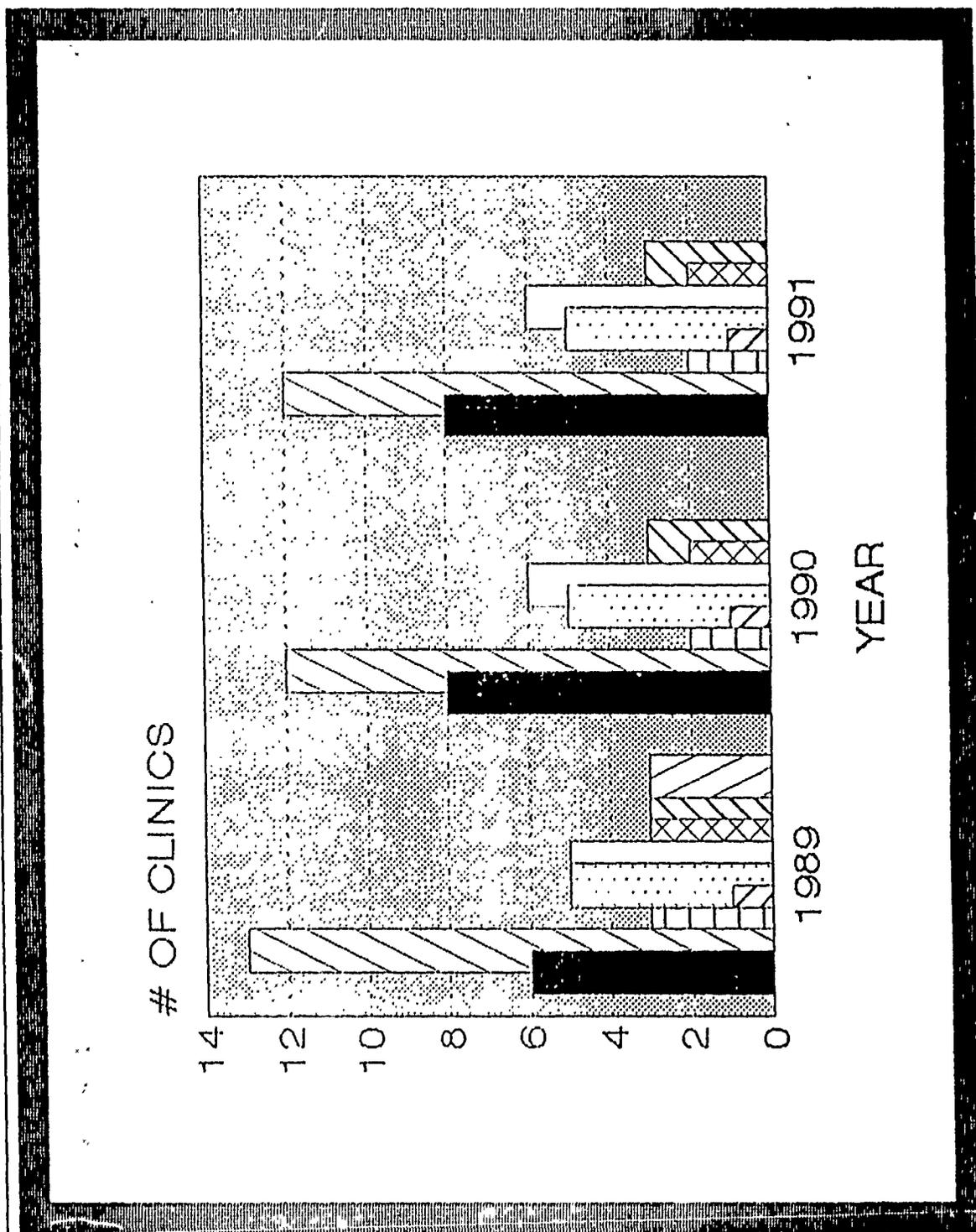
GEOGRAPHIC DISTRIBUTION OF MCI-ADMINISTERED HEALTH
CENTERS:

ACTIVE MCI CLINICS PER PROVINCE PER YEAR

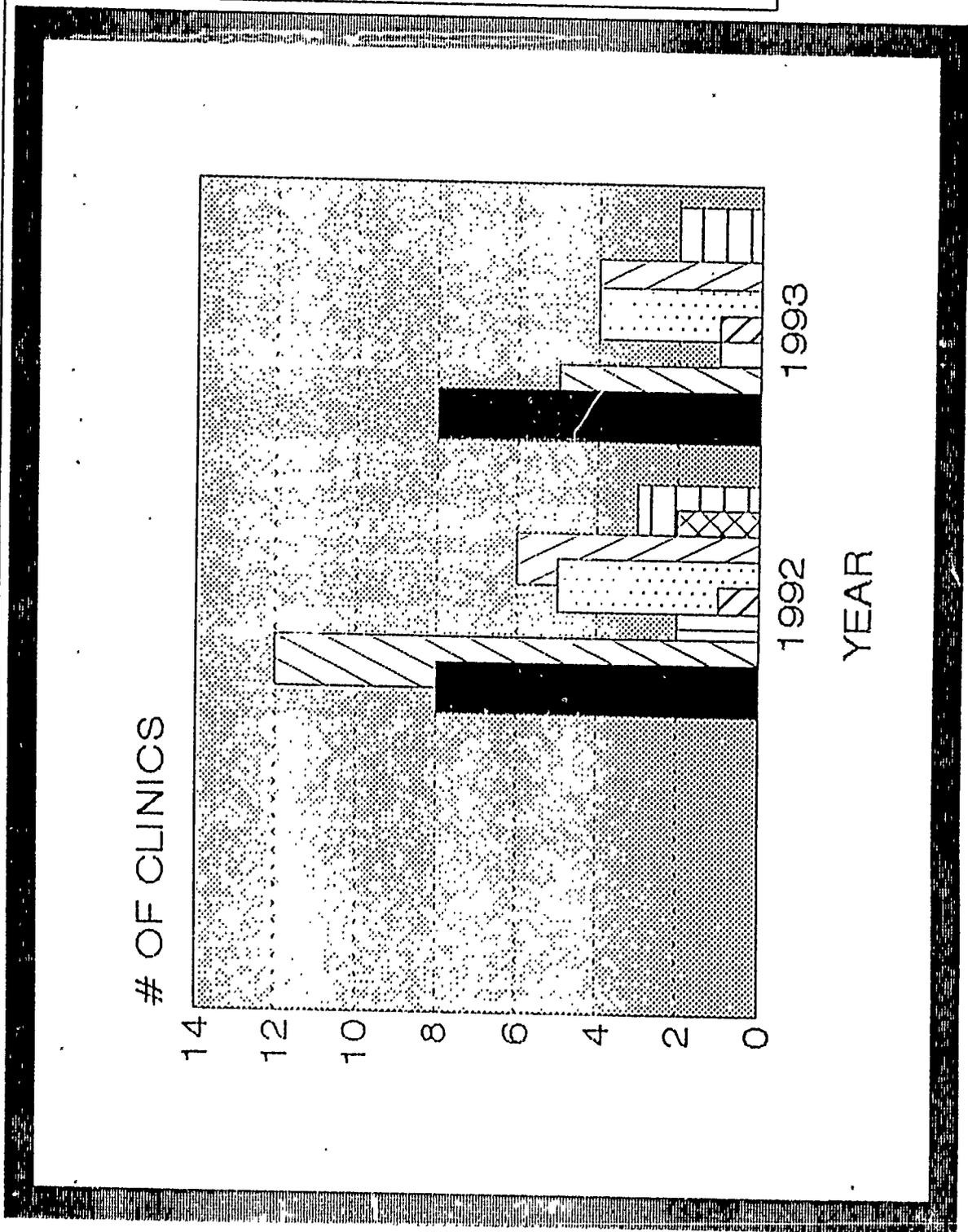
ACTIVE MCI CLINIC PER PROVINCE PER YEAR FROM 1986 TO 88 SUPPORTED BY USAID



ACTIVE MCI CLINICS PER PROVINCE PER YEAR FROM 1989 TO 91 SUPPORTED BY USAID



ACTIVE MCI CLINICS PER PROVINCE PER YEAR FROM 1991 TO 1993
SUPPORTED BY USAID



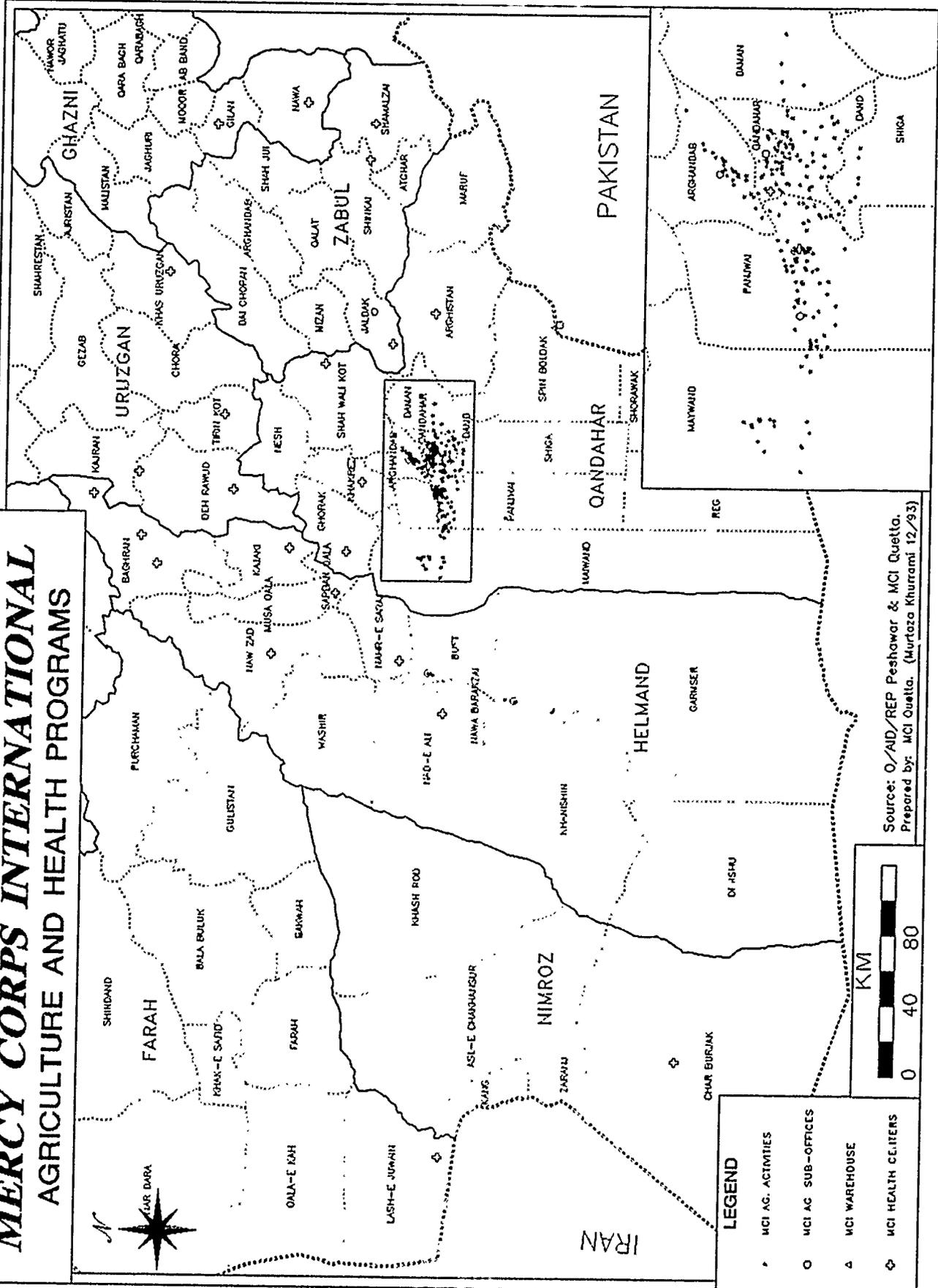
ANNEX 7B

GEOGRAPHIC DISTRIBUTION OF MCI-ADMINISTERED HEALTH
CENTERS:

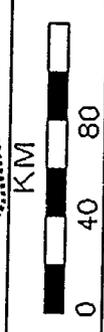
MAPS

MERCY CORPS INTERNATIONAL

AGRICULTURE AND HEALTH PROGRAMS

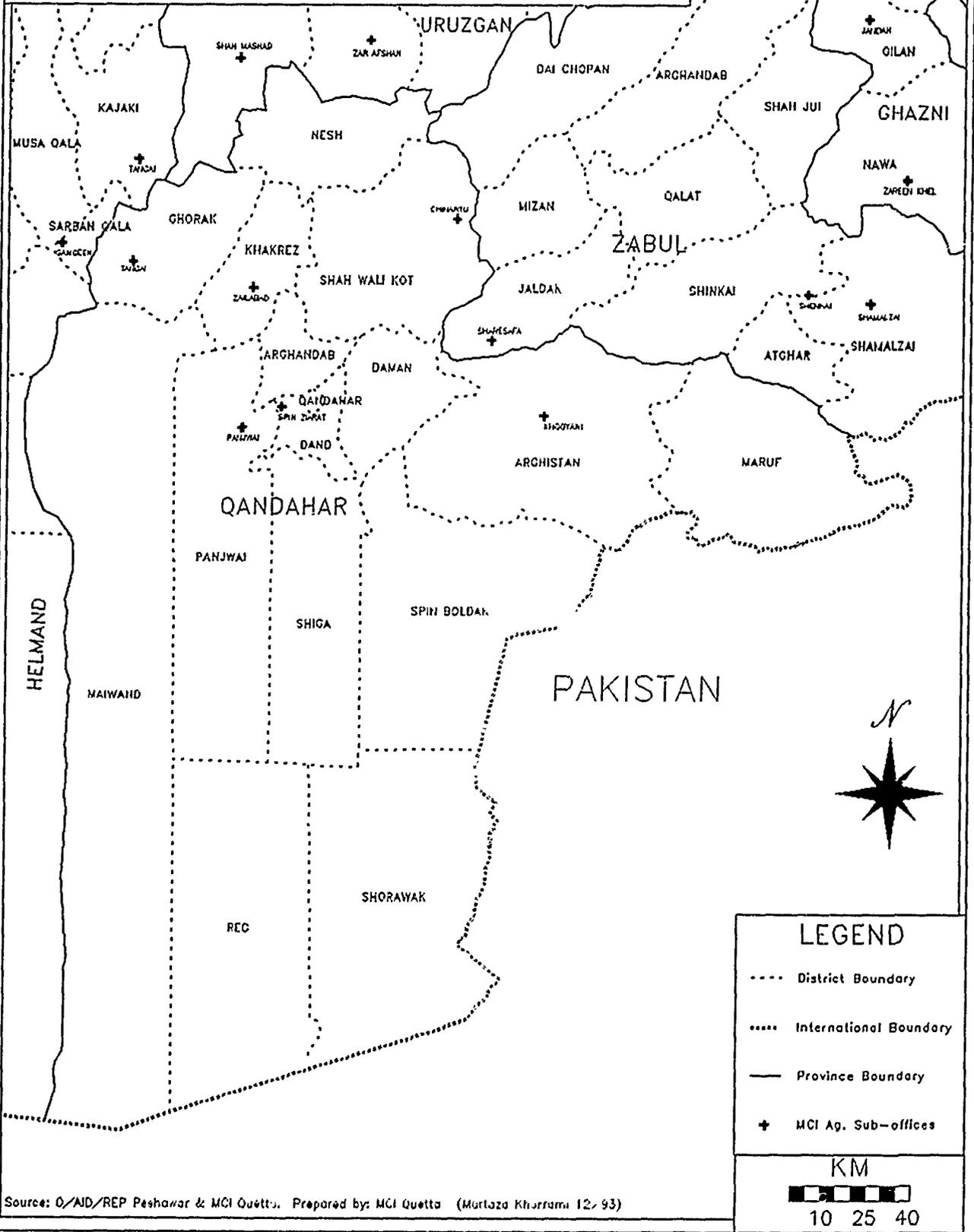


LEGEND	
●	MCI AG. ACTIVITIES
○	MCI AG SUB-OFFICES
△	MCI WAREHOUSE
◇	MCI HEALTH CENTERS



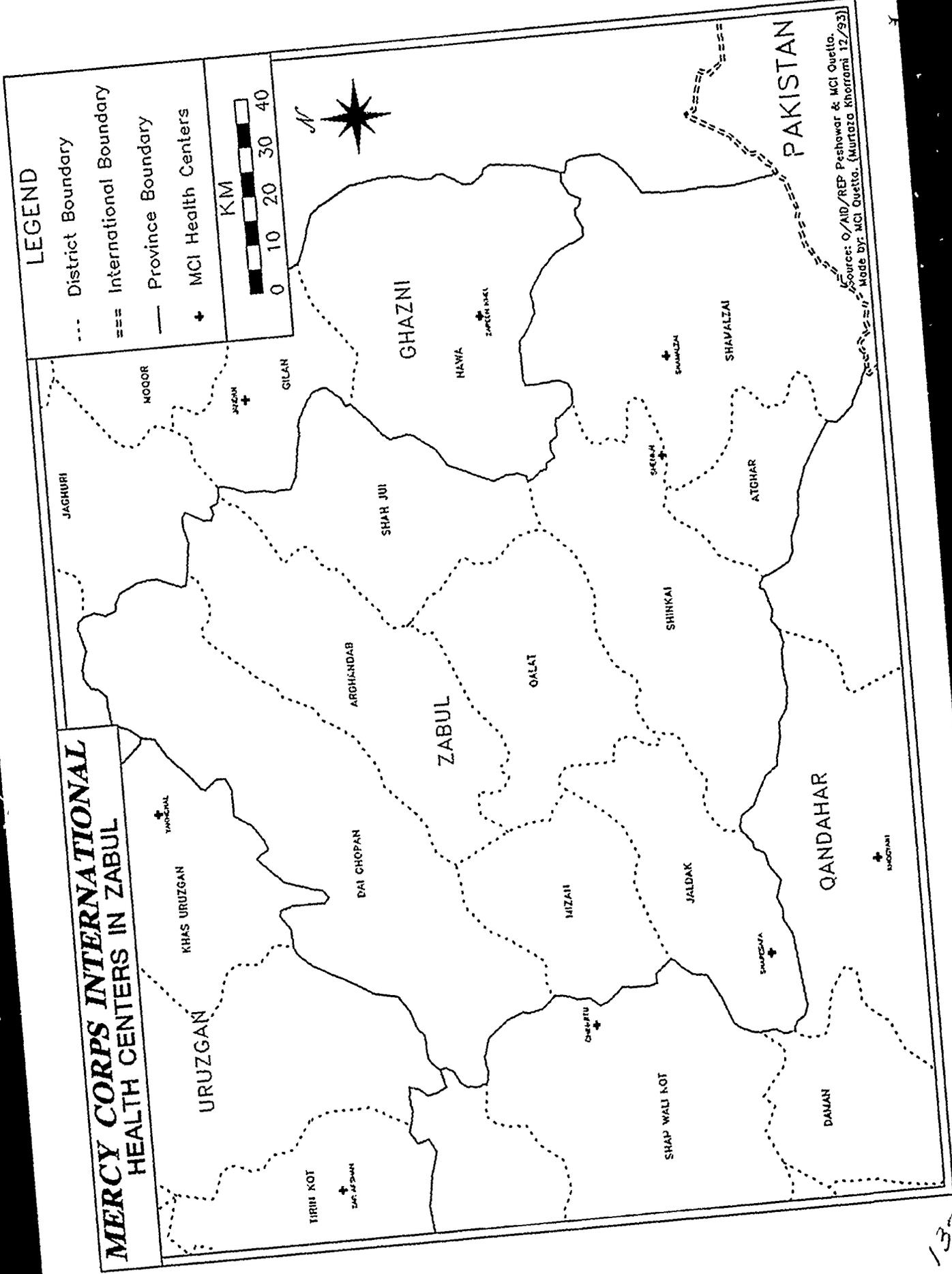
Source: O/AID/REP Peshawar & MCI Quetta.
 Prepared by: MCI Quetta. (Murtaza Khurrami 12/93)

MERCY CORPS INTERNATIONAL HEALTH CENTERS IN QANDAHAR



Source: O/AID/REP Peshawar & MCI Quetta. Prepared by: MCI Quetta (Murtaza Khurrami 12/93)

MERCY CORPS INTERNATIONAL HEALTH CENTERS IN ZABUL



LEGEND

- - - District Boundary
- === International Boundary
- Province Boundary
- + MCI Health Centers

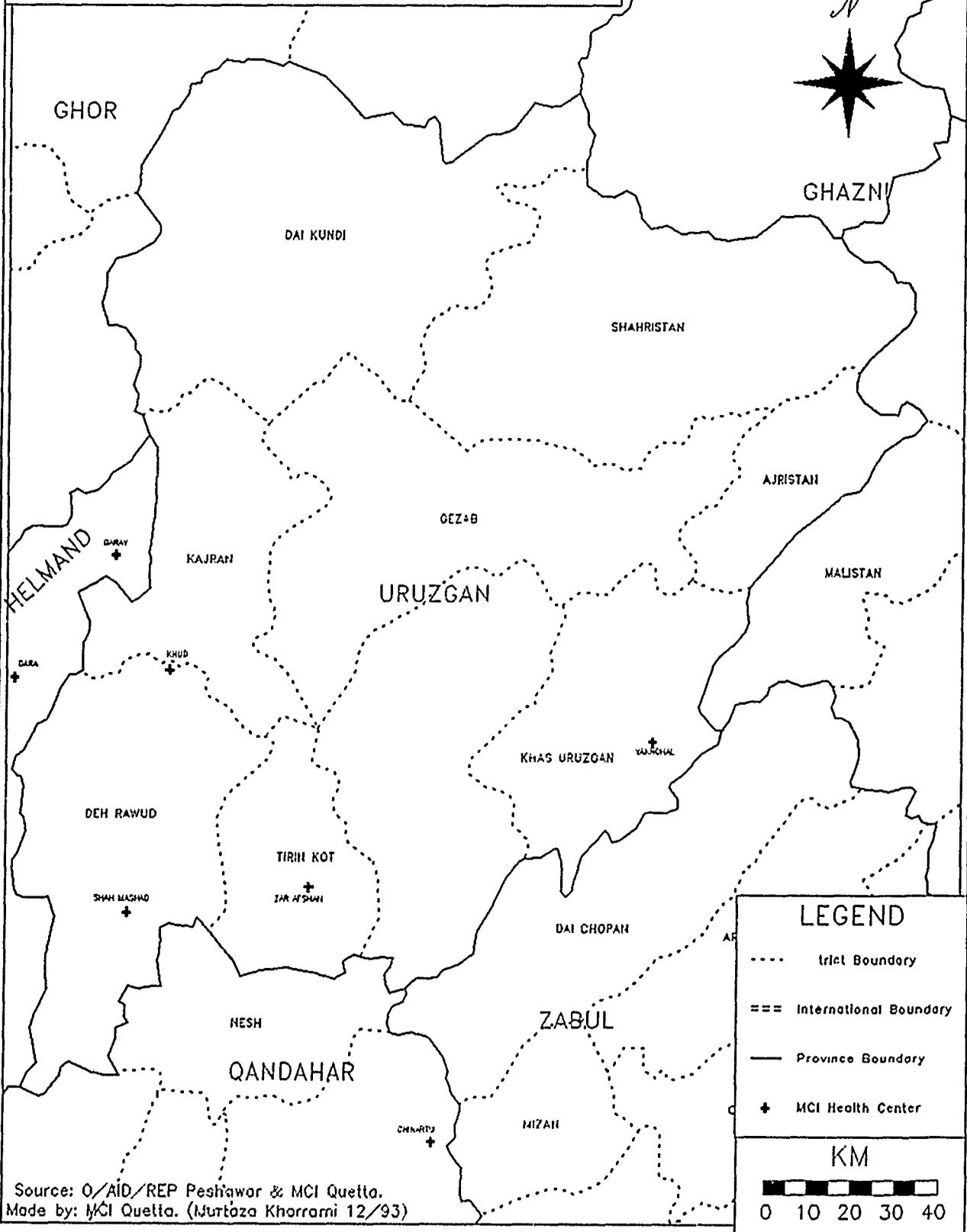


Source: O/AID/REP Peshawar & MCI Quetta.
Made by: MCI Quetta. (Murtaza Khorrani 12/93)

PAKISTAN

MERCY CORPS INTERNATIONAL

HEALTH CENTERS IN URUZGAN

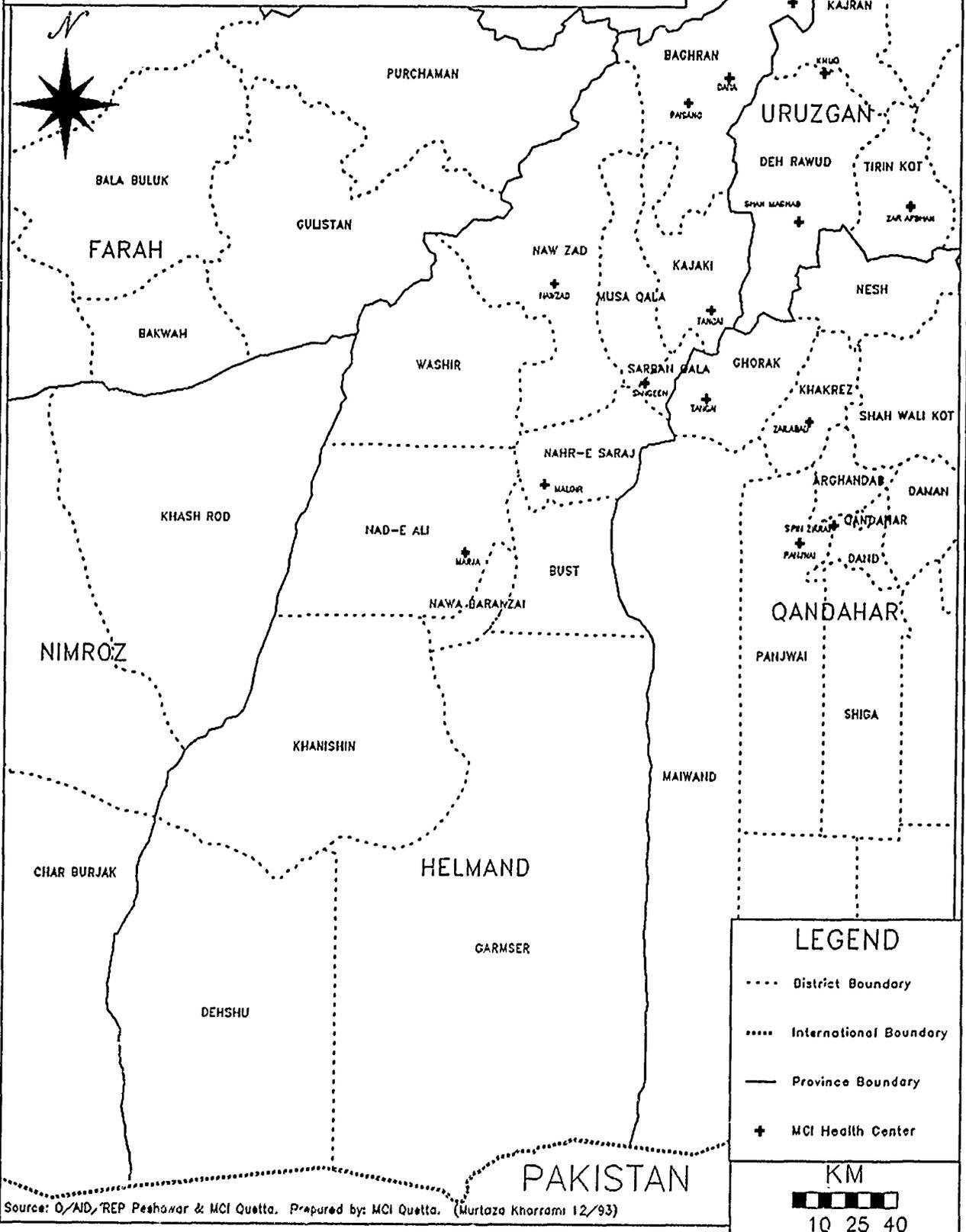


Source: O/AID/REP Peshawar & MCI Quetta.
 Made by: MCI Quetta. (Murtaza Khorrarni 12/93)

133

MERCY CORPS INTERNATIONAL

HEALTH CENTERS IN HELMAND



Source: O/AD, REP Peshawar & MCI Quetta. Prepared by: MCI Quetta. (Murtaza Khorrani 12/93)

LEGEND

- District Boundary
- International Boundary
- Province Boundary
- + MCI Health Center

KM

0 25 40

B-1

MERCY CORPS INTERNATIONAL HEALTH CENTER IN NIMROZ



WAH

FARAH

LASH-E JUWAIN

KOH CHI

KHASH ROD

ASL-E CHAKHANSUR

KANG

NIMROZ

IRAN

ZARANJ

KHANISHIN

HELMAND

CHAR BURJAK

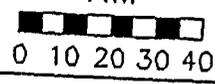
BANDAP-E NASIR

DEHSU

LEGEND

- - - - District Boundary
- International Boundary
- Province Boundary
- + MCI Health Center

KM

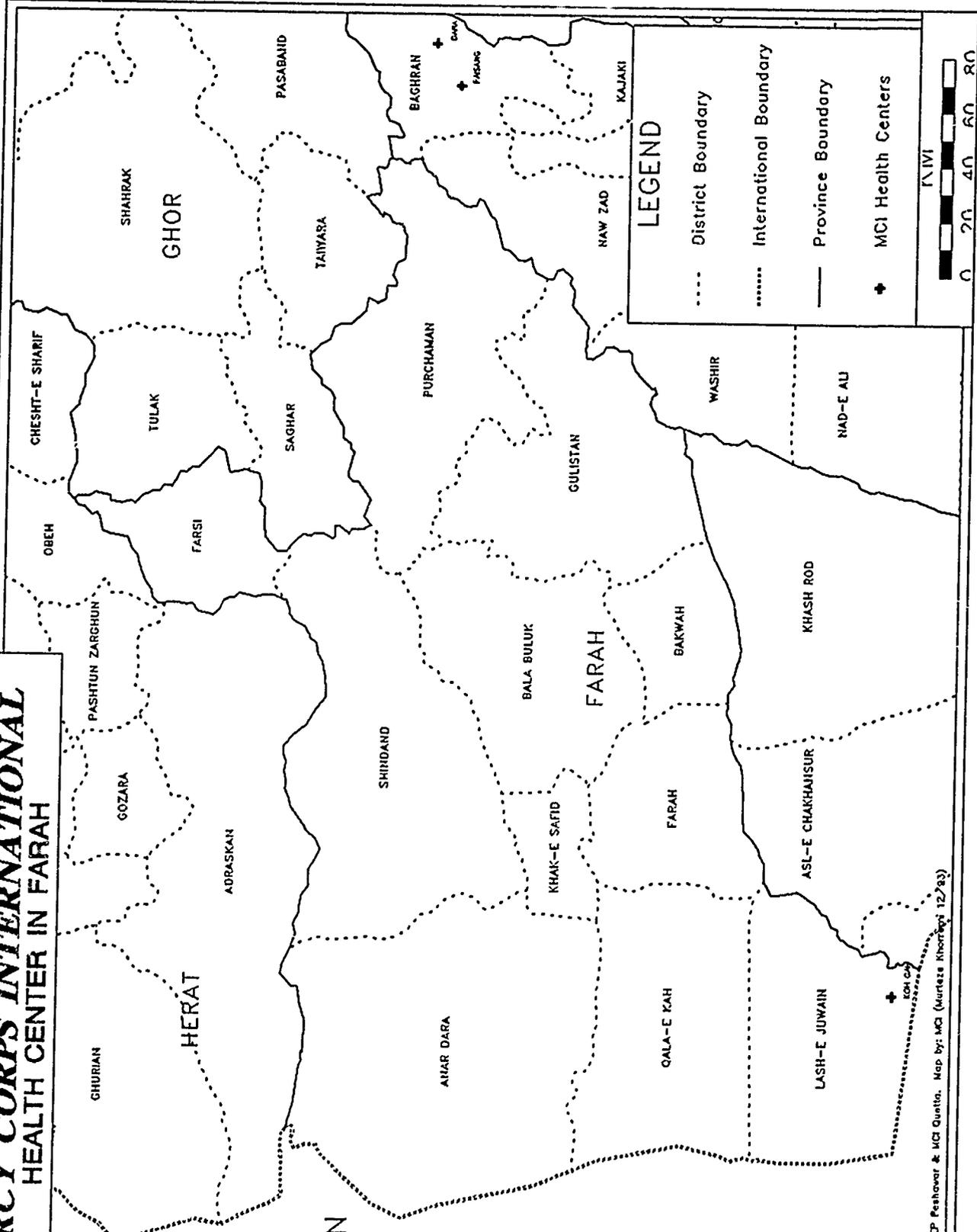


PAKISTAN

Source: O/AID/REP Peshawar & MCI Quetta. Prepared by: MCI Quetta. (Murtaza Khorrami 12/93)

140

MERCY CORPS INTERNATIONAL HEALTH CENTER IN FARAH



LEGEND

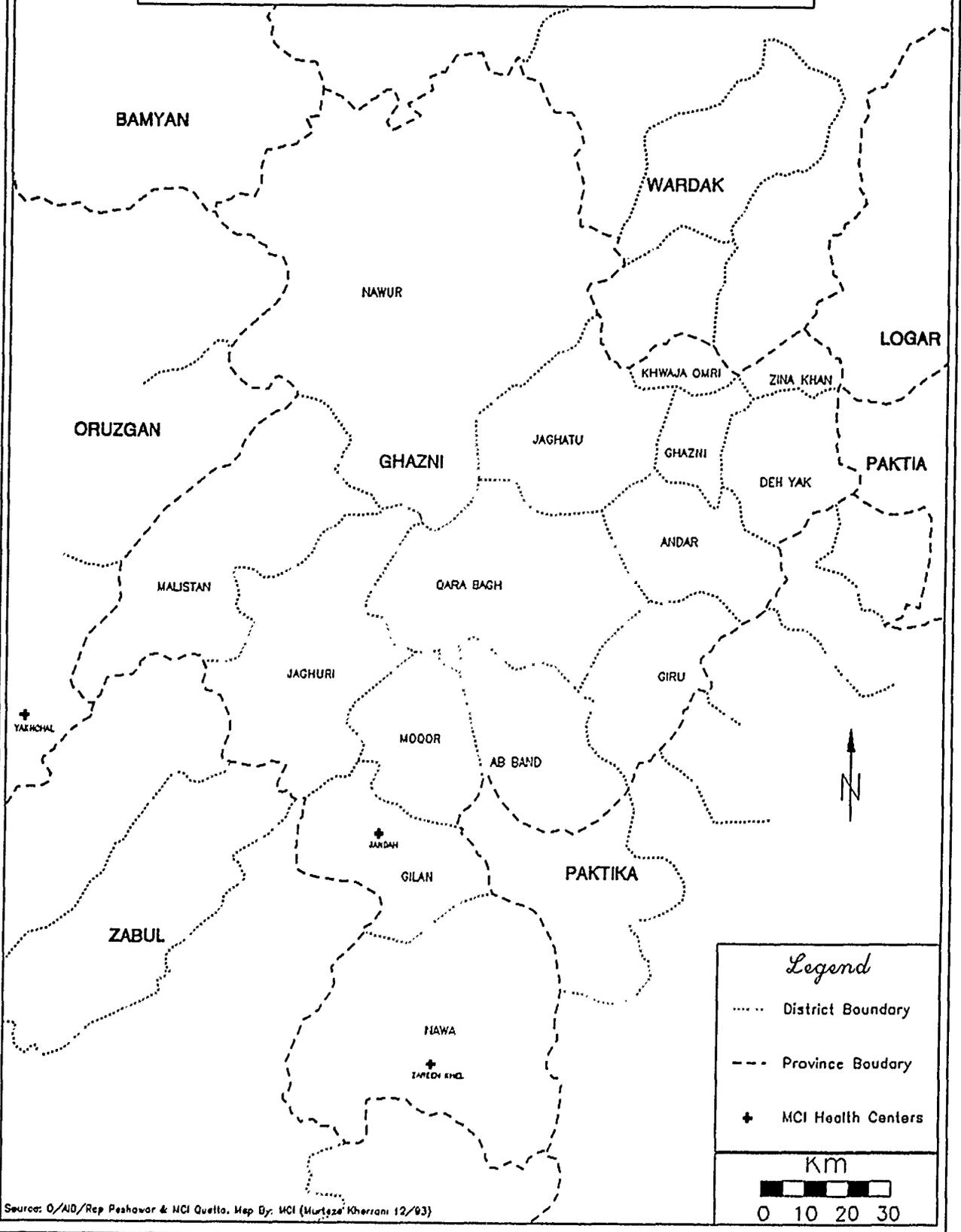
- - - District Boundary
- International Boundary
- Province Boundary
- + MCI Health Centers



Source: O/AD/REP Peshawar & MCI Quetta. Map by: MCI (Murteza Khattak) 12/83

141

MERCY CORPS INTERNATIONAL HEALTH CENTERS IN GHAZNI



Source: O/AID/Rep Peshawar & MCI Quetta. Map By: MCI (Murteza Kherrani 12/93)

Legend

- District Boundary
- - - Province Boundary
- + MCI Health Centers

km

0 10 20 30

142

ANNEX 7C

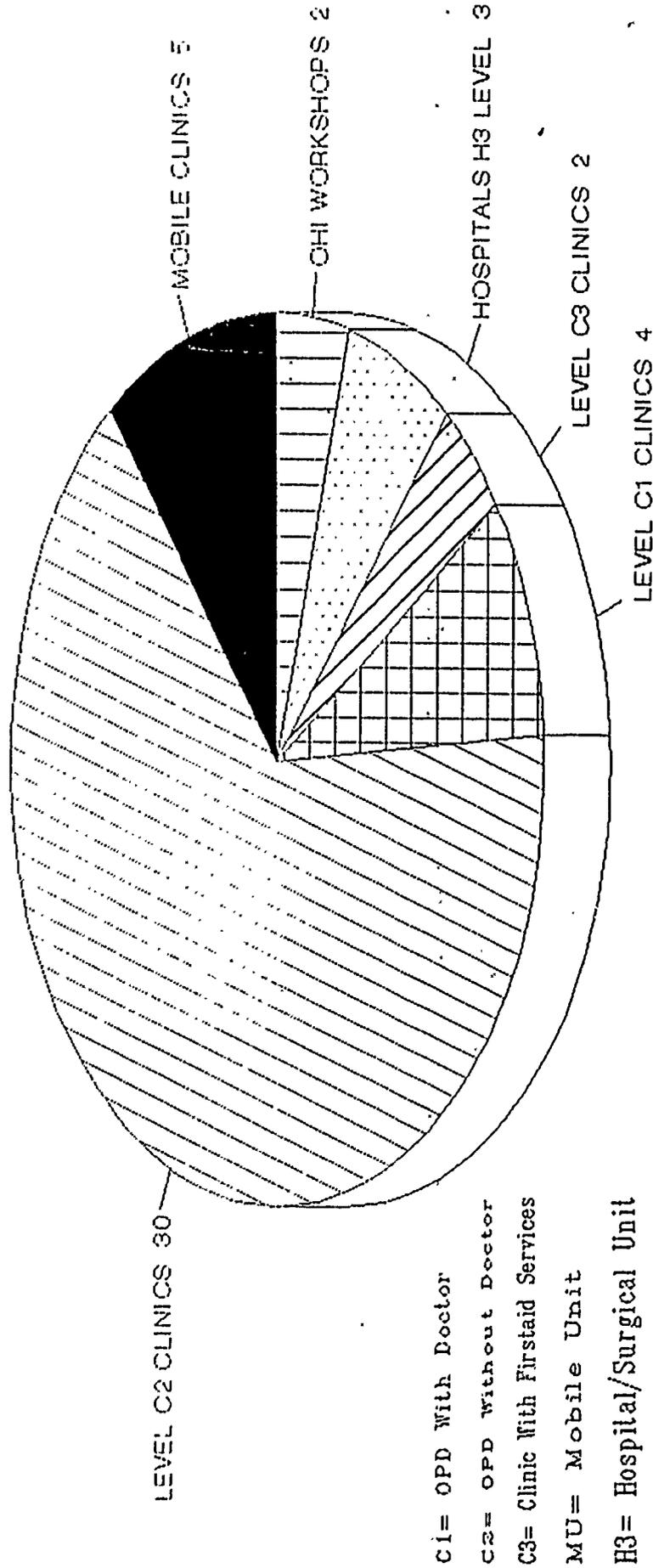
GEOGRAPHIC DISTRIBUTION OF MCI-ADMINISTERED HEALTH
CENTERS:

MCI CLINICS LEVEL BREAKDOWN PER YEAR

11/1

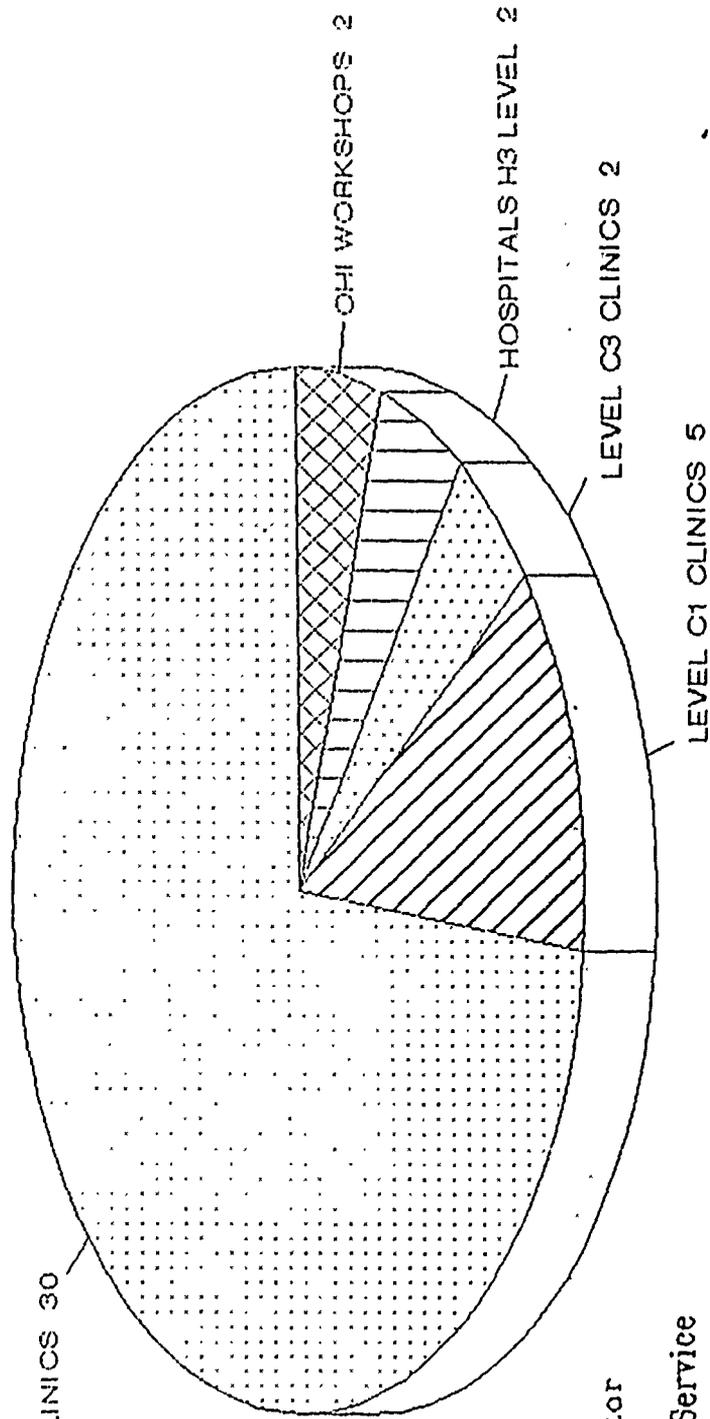
MCI CLINICS LEVEL BREAKDOWN

CENTERS IN 1991



1/4

MCI CLINICS LEVEL BREAKDOWN CENTERS IN 1992



C1= OPD With Doctor

C2= OPD Without Doctor

C3= Clinic With Firstaid Service

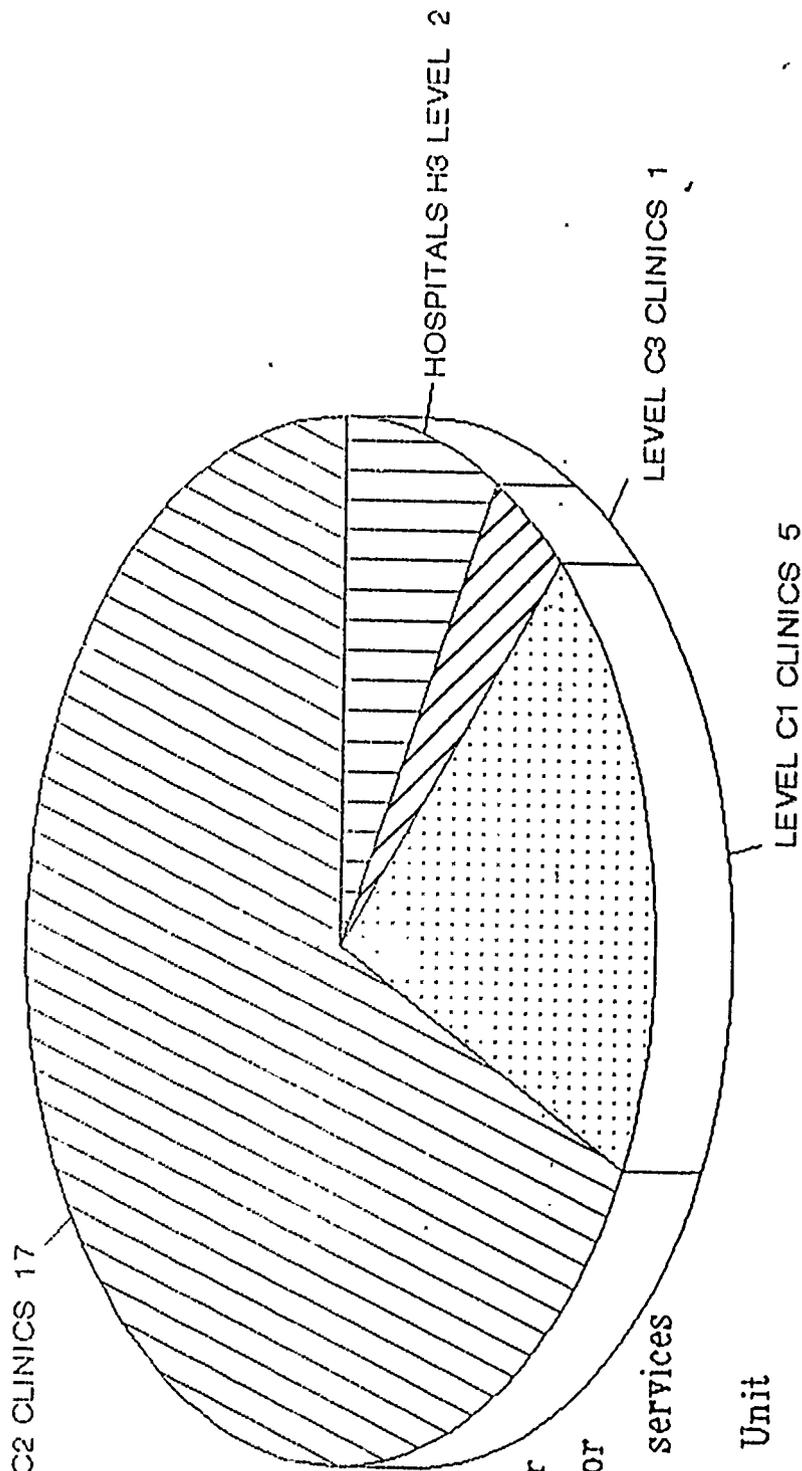
MU= Mobile Unit

H3= Hospital/Surgical Unit

1/5

MCI CLINICS LEVEL BREAKDOWN

CENTERS IN 1993



C1= OPD With Doctor

C2=OPD Without Doctor

C3= Clinic with firstaid services

MU= Mobile Unit

H3= Hospital/Surgical Unit

46

ANNEX 8REPORTS OF MCI-ADMINISTERED HEALTH CENTERS IN
AFGHANISTAN

- | | |
|----------------------|----------|
| 1. Facility location | 2. Codes |
| | Number |
| Party/Commander | Funder |
3. Statistics
- C-1 Physician, mid-level health worker +/- lab or dental technician
- C-2 Mid-level health worker +/- lab or dental technician
- C-3 Basic health worker
- H-3 Small hospital

Start date/planned close date

SERVICES

- A INPATIENT SERVICES
- B IMMUNIZATION
- C DAI (TBA) TRAINING
- D HEALTH WORKERS TRAINING
- E PATIENT AND COMMUNITY EDUCATION
- F PHYSIOTHERAPY
- G PROSTHESES
- H GENERAL SURGERY
- I ORTHOPEDIC SURGERY
- J OTHER SURGICAL SERVICES
- K DENTAL SERVICES
- L LABORATORY SERVICES
- M X-RAY SERVICES
- N TUBERCULOSIS CONTROL PROGRAM
- O MALARIA CONTROL PROGRAM
- P LEPROSY CONTROL PROGRAM
- Q GYNECOLOGICAL SERVICES
- R PREGNANCY CARE
- S DELIVERY
- T WELL-BABY CARE
- U ORT CORNER
- V OTHER

4. Last monitored/last medical supply
5. Quarterly salary distribution
6. Staff list

M C I HEALTH CENTER REPORT ***

Month 23 FEB 94

Quarter 3, 93

```

=====
1. Facility:
Village Nauzad
District Nauzad
Province Helmand
Party Hezbi-E-Islami (Hehmatyar)
Commander Nanwahi

2. Codes:
Village 02307000
MCD Code 02307
MCI # 2
Funder USAID
=====
    
```

```

=====
3. Statistics:
Level/Type C-2
Start date 01 JAN 89
Planned close date 31 OCT 93
Services E L K
=====
    
```

4. Last Monitored: 20 MAY 93 Last Medical Supply: 17 MAY 93

```

=====
JAN/JUL FEB/AUG MAR, SEP APR/OCT MAY/NOV JJN/DEC
    0          0          0      26,916      0          0
13,434          0      25,280          0          0
=====
    
```

6. Staff list:

LINE	EMP	NAME	POSITION	FATHER	Active	Drop
1	1020	Saeed Ghulam	Guard Day	Saeed Baqi	YES	
2	347	M Zahir	Midlevel Dental	Abdullah	YES	
3	345	Abdul Wahed	Midlevel Lab	Abdul Ghafoor	YES	
4	344	Abdul Gayum	Midlevel Opd	Mohd Rasol	YES	
5	1017	Mohammed Akber	Clerk	M Azim	YES	
6	294	Babo	Sweeper	Abdullah Khan	YES	
7	1021	Fazaldih	Sweeper	M. Meer	YES	
8	1019	Ahmad	Guard Day	Saeed Mohd	YES	

BEST AVAILABLE COPY

Notes:

143

MCI HEALTH CENTER REPORT #11

Month 23 FEB 94

Quarter 3, 93

```

=====
1. Facility:
Village Marja
District Nadi-Ali
Province Helmand
Party Hezbi-E-Islami (Helmatyar)
Commander Haq Been

2. Codes:
Village 02310700
MCD Code 02310
MCI # 10
Funder USAID
=====
    
```

```

=====
3. Statistics:
Level/Type C-2
Start date 23 JUN 88
Planned close date 31 OCT 93
Services B E K L
=====
    
```

```

=====
4. Last Monitored: 23 MAY 93
Last Medical Supply: 29 AUG 93
=====
    
```

JAN/JUL	FEB/AUG	MAR/SEP	APR/OCT	MAY/NOV	JUN/DEC
0	11,940	3,000	15,756	0	0
3,528	10,242	2,828	5,100	0	

6. Staff list:

LINE	EMP	NAME	POSITION	FATHER	Active, Drop
1	1093	Abdullah	Epi Vaccinator	Haji Firdouse	YES
2	464	Abdul Aziz	Midlevel Lab	Fazel Haq	YES
3	463	Mohd Mir	Midlevel Opd	Taj Mohd	YES
4	486	Mohmad Shah	Clerk	N/A	YES
5	1085	Noor Mohd	First Aid	Khan Mohd	YES
6	468	Amanullah	Sweeper	N/A	YES
7	470	Jan M	Guard Day	N/A	YES

Notes:

BEST AVAILABLE COPY

FBI MCI HEALTH CENTER REPORT

Month 23 FEB 94

Quarter 3. 93

1. Facility:	2. Codes:
Village Jalalzai	Village 02509030
District Shemalzai	MCD Code 02509
Province Zabul	
Party Khalis	MCI # 4
Commander Obaidullah	Funder USAID

3. Statistics:
 Level/Type C-2
 Start date 30 JAN 89
 Planned close date 31 OCT 93
 Services E K L

4. Last Monitored: 20 JUN 93 Last Medical Supply. 14 JUN 93

JAN/JUL	FEB/AUG	MAR/SEP	APR/OCT	MAY/NOV	JUN/DEC
1,445	0	0	3,881	0	43,821
0	0	23,852	0	0	

6. Staff list:

LINE	EMF	NAME	POSITION	FATHER	Active, Drop
1	669	Abdul Mutaleb	Midlevel Lab	Sultan Mohd	YES
2	1050	Mohd Akbar	Midlevel Dental	Feda Mohd	YES
3	668	Mohd Raza	Midlevel Opd	Mohd Rahim	YES
4	904	Rohullah	Clerk	Shaqzai	YES
5	770	Rahim Khan	Guard Day	N/A	YES
6	769	Ab. Hakim	Guard Day	N/A	YES

Notes:

BEST AVAILABLE COPY

154

M C I HEALTH CENTER REPORT

Month 23 FEB 94

Quarter 3, 93

1. Facility:		2. Codes:	
Village	Sheenkai	Village	02507027
District	Shinkai	MCD Code	02507
Province	Zabul	MCI #	23
Party	Mahaz-E-Milli (Gailani)	Funder	USAID
Commander	Salam Khan		

3. Statistics:

Level/Type H-3

Start date 15 JAN 88

Planned close date 31 OCT 93

Services A E F G K L M

4. Last Monitored: 18 JUN 93

Last Medical Supply: 14 JUN 93

JAN/JUL	FEB/AUG	MAR/SEP	APR/OCT	MAY/NOV	JUN/DEC
4,293	0	18,158	5,658	2,329	27,237
9,079	12,339	50,622	5,658	0	

6. Staff list:

LINE	EMF	NAME	POSITION	FATHER	Active	Drop
1	1066	Dr. Mohd Anwar	Doctor	Abdul Rouf	YES	
2	458	Faynda Moid	Midlevel Xray	Ghulam Mohd	YES	
3	380	Abdullah	Midlevel Ward	Mohd Zarif	YES	
4	290	Noor Hasan	Midlevel Ward	Fateh Mohd	YES	
5	381	Abdul Latif	Midlevel Lab	Abdul Rahim	YES	
6	382	Delbar	Midlevel Dental	Mohd Nisir	YES	
7	459	Abdul Hakim	Midlevel Opd	Abdul Baqi	YES	
8	379	Abdul Latif	Midlevel Opd	Durani	YES	
9	383	A Salam	Clerk	N/A	YES	
10	970	Sardar Khan	Cook	Jalat Khan	YES	
11	972	Hassan Jan	Guard Day	Aminullah	YES	
12	387	Abdul Qadus	Guard Day	N/A	YES	
13	973	Abdul Ghafoor	Guard Day	M. Janan	YES	
14	990	Ghulam Sakhi	Guard Day	Mohammad Akber	YES	
15	289	Mohd Anwar	Midlevel Ot	Mohd Umar	YES	
16	288	Abdul Wahid	Midlevel Opd	Fazal Mohd	YES	
17	391	Said M	Sweeper	N/A	YES	
18	971	Abdul Rahim	Guard Day	Nasir	YES	
19	974	Abdul Raziq	Driver	Ezatullah	YES	

Notes:

BEST AVAILABLE COPY

151

MCI HEALTH CENTER REPORT III

Month 23 FEB 94

Quarter 3, 93

1. Facility:		2. Codes:	
Village	Shar-I-Safa	Village	02502070
District	Shahrisafa	MCD Code	02501
Province	Zabul	MCI #	190
Party	Hezbi-E-Islami (Khalis)	Funder	USAID
Commander	Granai		

3. Statistics:
 Level/Type C-1
 Start date 30 NOV 90
 Planned close date 31 OCT 93
 Services B E J L

4. Last Monitored: 13 JUN 93 Last Medical Supply: 23 SEP 93

JAN/JUL	FEB/AUG	MAR/SEP	APR/OCT	MAY/NOV	JUN/DEC
1,700	13,062	1,500	7,413	14,026	0
5,313	8,713	14,270	3,400	0	

6. Staff list:

LINE	EMP	NAME	POSITION	FATHER	Active	Drop
1	976	Mohd Hamayoon	Vaccinator/Monitor	N/A	YES	
2	975	Dr. Mohd Arif	Doctor	Ghulam Ali	YES	
3	917	Ali Ahmad	Clerk	N/A	YES	
4	978	Akhtar Mohd	Sweeper	Mohd	YES	
5	979	Toryali	Guard Day	Habibullah	YES	
6	980	Aziaullah	Guard Day	Fatah	YES	
7	855	Hakimullah	Midlevel Lab	Abdullah	YES	

Notes:

BEST AVAILABLE COPY

157

M C I HEALTH CENTER REPORT ***

Month 23 FEB 94

Quarter 3, 90

```

=====
1. Facility:
Village Chinartoo
District Mizan
Province Zabul
Party Jamiat-E-Islami (Rabbani)
Commander Ata Jan

2. Codes:
Village 02503700
MCD Code 02503
MCI # 99
Funder USAID
=====
    
```

```

=====
3. Statistics:
Level/Type C-2
Start date 28 MAR 89
Planned close date 31 OCT 93
Services E K L
=====
    
```

```

=====
4. Last Monitored: 15 MAY 93 Last Medical Supply: 12 JUL 93
=====
    
```

JAN/JUL	FEB/AUG	MAR/SEP	APR/OCT	MAY/NOV	JUN/DEC
26,325	0	0	0	0	0
18,516	0	18,516	0	0	

6. Staff list:

LINE	EMP	NAME	POSITION	FATHER	Active/Drop
1	281	Ahmad Ballal	Midlevel Lab	Khudinazar	YES
2	663	Saheb Jan	Midlevel Dental	Mohd Jan	YES
3	664	Fiaz M	Clerk	N/A	YES
4	666	M. Hassan	Guard Day	N/A	YES
5	667	Agha Wali	Guard Day	N/A	YES

BEST AVAILABLE COPY

Notes:

HEALTH CENTER REPORT

Month 23 FEB 94

Quarter 3, 93

1. Facility:	2. Codes:
Village Zar Afshan	Village 02601701
District Tirin Kot	MCD Code 02601
Province Oruzgan	
Party Khalis	MCI # 22
Commander Abdul Malik	Funder USAID

3. Statistics:
 Level/Type C-1
 Start date 17 JAN 88
 Planned close date 31 OCT 93
 Services A E L K L M

4. Last Monitored: 02 JAN 93 Last Medical Supply: 13 SEP 93

JAN/JUL	FEB/AUG	MAR/SEP	APR/OCT	MAY/NOV	JUN/DEC
0	0	30,312	14,106	0	0
3,850	17,307	30,450	0	0	

6. Staff list:

LINE	EMP	NAME	POSITION	FATHER	Active, Drop
1	372	Abdullah	Midlevel Lab	Ghulam Dastagir	YES
2	371	Mohd Masoom	Midlevel Dental	Abdul Qayum	YES
3	370	Azizullah	Midlevel Xray	Shah Mohd	YES
4	292	Aminullah	Midlevel Dental	Luqman	YES
5	909	Amanullah	Clerk	Abdul Aziz	YES
6	907	Naik Mohd	First Aid	Mohd Rahim	YES
7	377	Ghulam Jan	Cook	N/A	YES
8	908	Bora	Sweeper	N/A	YES
9	374	Lal M	Sweeper	N/A	YES
10	375	A Wahid	Guard Day	N/A	YES
11	376	M Hussian	Guard Day	N/A	YES
12	291	Mohd Aklas	Midlevel Opd	Peer Mohd	YES

BEST AVAILABLE COPY

Notes:

M C I HEALTH CENTER REPORT

Month 23 FEB 94

Quarter 5, 93

1. Facility:	2. Codes:
Village Yakhchal	Village 02602670
District Oruzgan	MCD Code 02602
Province Oruzgan	
Party Party Not Listed	MCI # 191
Commander	Funder USAID

3. Statistics:
 Level/Type C-2
 Start date 14 MAY 91
 Planned close date 31 OCT 93
 Services E

4. Last Monitored: 28 MAY 93 Last Medical Supply: 12 JUL 93

JAN/JUL	FEB/AUG	MAR/SEP	APR/OCT	MAY/NOV	JUN/DEC
22,050	0	0	0	0	0
12,738	8,492	0	0	0	

6. Staff list:

LINE	EMP	NAME	POSITION	FATHER	Active/Drop
1	614	Wakil Ahmad	Midlevel Opd	Fazel Mohd	YES
2	925	Ab Salam	Bhw First Aid	N/A	YES
3	943	Abdul Rouf	Clerk	Mohd J	YES
4	944	Asadullah	First Aid	Kalandar	YES
5	1195	Khalidad	Drv Trctr	Haji Obaidullah	09 APR 71
6	1194	Daud Shah	Guard Day	Abdul Qaum	08 APR 71
7	978	Akhtar Mohd	Sweeper	Mohd	YES
8	979	Toryali	Guard Day	Habibullah	YES
9	980	Aziaullah	Guard Day	Fatah	YES
10	917	Ali Ahmad	Clerk	N/A	YES
11	976	Mohd Hamayoon	Vaccinator/Monitor	N/A	YES
12	975	Dr. Mohd Arif	Doctor	Ghulam Ali	YES

BEST AVAILABLE COPY

Notes:

105-

MCI HEALTH CENTER REPORT

Month 23 FEB 94

Quarter 3, 93

1. Facility:

Village Khod
 District Kajran
 Province Oruzgan
 Party Nijat
 Commander Mullah Abdul Haq

2. Codes:

Village 02603701
 MCD Code 02609
 MCI # 7
 Funder USAID

3. Statistics:

Level/Type C-2
 Start date 30 APR 87
 Planned close date 31 OCT 93
 Services E K L

4. Last Monitored: 22 MAY 93

Last Medical Supply: 16 AUG 93

JAN/JUL	FEB/AUG	MAR/SEP	APR/OCT	MAY/NOV	JUN/DEC
36,438	0	0	0	0	0
0	40,490	0	0	0	0

6. Staff list:

LINE	EMP	NAME	POSITION	FATHER	Active	Drop
1	633	Said Gul	Midlevel Lab	M.Yar	YES	
2	1191	Mohd Omar	Midlevel Dental	H. Dad Mohd		05 APR 71
3	1192	Mir Hatam	Midlevel Opd	H. Dad Ullah		06 APR 71
4	1033	Abdul Shakoor	Clerk	Mohd Gull	YES	
5	1031	Mohdullah	Guard Day	Khudaidad	YES	
6	1032	Khan Mohd	Sweeper	Abdul Mohd	YES	

BEST AVAILABLE COPY

Notes: F

152

M C I HEALTH CENTER REPORT

Month 03 FEB 94

Quarter 3, 93

1. Facility:		2. Codes:	
Village	Shah Mash Had	Village	02603045
District	Deh Raud	MCD Code	02603
Province	Oruzgan	MCI #	9
Party	Hezbi-E-Islami (Hakmatyar)	Funder	USAID
Commander	Dr. Wazir		

3. Statistics:

Level/Type C-2
 Start date 30 MAY 88
 Planned close date 31 OCT 93
 Services E K L Q R S

4. Last Monitored: 20 MAY 93

Last Medical Supply: 13 SEP 93

JAN/JUL	FEB/AUG	MAR/SEP	APR/OCT	MAY/NOV	JUN/DEC
25,440	0	0	0	0	0
0	0	49,313	0	0	

6. Staff list:

LINE	EMP	NAME	POSITION	FATHER	Active, Drop
1	2005	Jamila	Asst Mch	Amanullah	27 JUN 73
2	352	Wazir Mohd	Nurse Head	Badiul Zaman	YES
3	358	A Karim	Sweeper	N/A	YES
4	948	Bismillah	Guard Day	Ghulam Sarwar	YES
5	918	Abdul Jalil	Clerk	N/A	YES
6	353	Abdul Razaq	Midlevel Opd	Ali Mohd	YES
7	354	Ghulam Mohd	Midlevel Dental	Saleh Mohd	YES
8	293	Dost Mohd	Midlevel Lab	Badi-Ul-Zaman	YES

BEST AVAILABLE COPY

Notes:

157

*** M C I HEALTH CENTER REPORT ***

Month 23 FEB 94

Quarter 3, 93

1. Facility:

Village Bandar-I-Naseer
 District Char Boriak
 Province Nimroz
 Party Harakat-E-Engelab (Mahamedi)
 Commander Abdul Karim

2. Codes:

Village 02205003
 MCD Code 02205
 MCI # 134
 Funder USAID

3. Statistics:

Level/Type C-1
 Start date 30 NOV 90
 Planned close date 31 OCT 93
 Services A E J K L

4. Last Monitored: 08 SEP 92

Last Medical Supply: 11 AUG 93

JAN./JUL	FEB./AUG	MAR./SEP	APR./OCT	MAY/NOV	JUN./DEC
0	44,048	0	0	0	0
0	29,296	0	43,944	0	

5. Staff List:

LINE	EM#	NAME	POSITION	FATHER	Active, Drop
1	844	Mulim Hstair A	Doctor	Khudidat	YES
2	887	Ab. Saber	Midlevel Dental	Mohd Anwar	YES
3	810	Ehsanullah	Midlevel Lab	Mohd Umar	YES
4	892	Ghulam Nabi	Clerk	Abdul Nabi	YES
5	886	Mohd Ismael	Midlevel Opd	Mohd Omar	YES
6	888	Mohd Sawar	First Aid	Agha Mohd	YES
7	889	Malang	Guard Day	N/A	YES
8	890	Ab. Rahim	Sweeper	N/A	YES

Notes:

M C I HEALTH CENTER REPORT

Month 23 FEB 94

Quarter 3, 93

1. Facility:	2. Codes:
Village Panjwaae	Village 02413000
District Panjwai	MCD Code 02413
Province Kandahar	
Party Party Not Listed	MCI # 196
Commander	Funder USAID

3. Statistics:

Level/Type C-2

Start date 13 MAY 91

Planned close date 31 OCT 93

Services E B F G Q R S

4. Last Monitored: 27 MAY 93

Last Medical Supply: 16 AUG 93

JAN/JUL	FEB/AUG	MAR/SEP	APR/OCT	MAY/NOV	JUN/DEC
26,825	0	1,563	12,969	9,828	14,855
9,007	4,815	14,610	0	14,610	

6. Staff list:

LINE	EMF	NAME	POSITION	FATHER	Active/Drop
1	894	Mohd Sadiq	Epi Vaccinator	Dad Mohd	YES
2	963	Sultan Mohd	Sweeper	Mohd Zarif	YES
3	961	Niaz Mohd	Guard Day	Said Mohd Shah	YES
4	1092	Shah Babo	Sweeper	Gh. Rasool	YES
5	1132	Abdul Shakoor	Clerk	Mohammed Rahim	YES
6	1069	Abdul Bari	Midlevel Opd	Malik Mohd	YES
7	918	Mohd Nadir	Midlevel Opd	Haji Noorullah	YES
8	915	Najibullah	Lab Tech	Ghulam Mohiuddi	YES
9	1068	Nargis	Mch Nurse	Ab. Ghafoor	YES
10	1023	Boor Mohd	Guard Day	Mohd Boor	YES
11	1024	Amanullah	Guard Day	Aminullah	YES
12	1022	Mohd Wali	Cook	Wali Mohd	YES
13	1084	Hayatullah	Technician	Dad Mohd	YES
14	834	Mawlada	Technician	Gh. Rasul	YES
15	833	Essa M	Technician	M. Ghose	YES
16	913	Neda Mohd	Supervisor	N/A	YES

Notes:

M C I HEALTH CENTER REPORT

Month 23 FEB 94

Quarter 3, 93

1. Facility:		2. Codes:	
Village	Zail Abad	Village	02407013
District	Khakraiz	MCD Code	02407
Province	Kandahar	MCI #	26
Party	Mahaz-E-Milli (Gailani)	Funder	USAID
Commander	Z. Akram		

3. Statistics:

Level/Type C-1

Start date 08 MAR 88

Planned close date 31 OCT 93

Services A B E J K L

4. Last Monitored: 22 JUN 93

Last Medical Supply: 12 JUL 93

JAN/JUL	FEB/AUG	MAR/SEP	APR/OCT	MAY/NOV	JUN/DEC
44,482	1,500	2,463	936	33,578	993
8,079	5,842	27,473	0	0	

6. Staff list:

LINE	EMP	NAME	POSITION	FATHER	Active, Drop
1	1094	Mohd Akbar	Epi Vaccinator	Abdul Ali	YES
2	677	M. Anwar	Cook	N/A	YES
3	678	Nanai	Guard Day	N/A	YES
4	679	Baridad	Guard Day	N/A	YES
5	942	Mohd Anwar	Clerk	Abdul Halim	YES
6	675	Mahmood	Midlevel Opd	Shah Jahan	YES
7	282	Mohd Ibrahim	Midlevel Lab	Abdul Majid	YES
8	676	Gul Agha	Midlevel Dental	Abdul Hakim	YES

Notes:

M C I HEALTH CENTER REPORT 111

Month 23 FEB 94

Quarter 3, 93

1. Facility:

Village Tangai
 District Ghorak
 Province Kandahar
 Party Nifa
 Commander Mula Jafar

2. Codes:

Village # 408700
 MCD Code 02403
 MCI # 114
 Funder USAID

3. Statistics:

Level/Type C-2
 Start date 18 MAR 90
 Planned close date 31 OCT 93
 Services E K L

4. Last Monitored: 18 JUN 93

Last Medical Supply: 19 JUN 93

JAN/JUL	FEB/AUG	MAR/SEP	APR/OCT	MAY/NOV	JUN/DEC
0	0	0	0	0	22.762
0	0	15,807	0	0	

6. Staff list:

LINE	EMF	NAME	POSITION	FATHER	Active	Drop
1	807	Niamatullah	Midlevel Lab	Rahmatullah	YES	
2	808	Mohd Qasim	Midlevel Dental	Mohd Hashim	YES	
3	1041	Naimatullah	Clerk	Mohd Akhlac	YES	
4	773	Ab Jalil	Sweeper	N/A	YES	
5	774	M. Juma	Guard Day	N/A	YES	
6	776	Baridab	Guard Day	N/A	YES	
7	881	Sabar Gul	Nurse	Haji Abdullah	YES	
8	772	Abdul Qadus	Midlevel Opd	Misrai	YES	

Notes:

111 N C I HEALTH CENTER REPORT 111

Month 23 FEB 94

Quarter 3, 93

```

=====
1. Facility:
Village Spin Ziarat
District Dand
Province Kandahar
Party Hezbi-E-Islami (Hakmatyar)
Commander Ata Mohd

2. Codes:
Village 02404701
NCD Code 02404
NCI # 178
Funder USAID
=====
    
```

```

=====
3. Statistics:
Level/Type C-2
Start date 28 NOV 90
Planned close date 31 OCT 93
Services E L
=====
    
```

4. Last Monitored: 25 MAY 93 Last Medical Supply: 04 JUL 93

```

=====
JAN/JUL FEB/AUG MAR/SEP APR/OCT MAY/NOV JUN/DEC
  2,890  10,708      0      8,098  1,928      0
=====
  4,691   2,889  19,107      0      0
=====
    
```

6. Staff list:

LINE	EMP	NAME	POSITION	FATHER	Active, Inop
1	1048	Hakim Dad	Midlevel Lab	Sakhi Dad	YES
2	919	Rohani	Ehw First Aid	Mohd Rasool	YES
3	812	Abdul Bari	Midlevel Opd	Talib Mohd	YES
4	921	Enayatullah	Clerk	Arif	YES
5	923	Kaker	Guard Day	Khan Mohd	YES
6	924	Mohd Naeem	Sweeper	Hejran	YES
7	920	Mohamad	Midlevel Opd	Gh Mohamad	YES

Notes:

162

191 M C I HEALTH CENTER REPORT 1-11

Month 23 FEB 94

Quarter 3, 93

```

=====
1. Facility:
Village Khogyani
District Arghistan
Province Kandahar
Party Nijat
Commander Md

2. Codes:
Village 02406019
MCD Code 02406

NCI # 15
Funder USAID
=====
    
```

```

=====
3. Statistics:
Level/Type C-2
Start date 30 JUL 87
Planned close date 31 OCT 93
Services E K
=====
    
```

4. Last Monitored: 20 MAY 93 Last Medical Supply: 11 OCT 93

JAN/JUL	FEB/AUG	MAR/SEP	APR/OCT	MAY/NOV	JUN/DEC
0	17,802	17,802	11,868	0	0
11,868	0	0	23,736	0	

6. Staff list:

LINE	EMF	NAME	POSITION	FATHER	Active, Drop
1	534	Abdul Ali	Midlevel Dental	Abdul Hakim	YES
2	536	Abdul Gayoum	Midlevel Opd	N/A	YES
3	1042	Aqua Jan	Clerk	Haji Delo Jan	YES
4	914	Abdul Nafah	First Aid	Noor Mohd	YES
5	537	Hamidullah	Ehw First Aid	Mohd Hussain	YES
6	1044	Din Mohd	Guard Day	Mohd Ibrahim	YES
7	1043	Mohd Ayub	Guard Day	Abdullah	YES

Notes:

F F I M C I HEALTH CENTER REPORT

Month 23 FEB 94

Quarter 3, 93

```

=====
1. Facility:
Village Sangin
District Sarbon Qala
Province Helmand
Party Jamiat-E-Islami (Rabbani)
Commander Ata Mohd

2. Codes:
Village 02304007
MCD Code 02304
MCI # 110
Funder USAID
=====
    
```

```

=====
3. Statistics:
Level/Type C-2
Start date 07 FEB 90
Planned close date 31 OCT 93
Services E K L
=====
    
```

4. Last Monitored: 14 JUN 93 Last Medical Supply: 11 AUG 93

```

=====
JAN/JUL FEB/AUG MAR/SEP APR/OCT MAY/NOV JUN/DEC
    0          0          0      13,164    8,740        0
5,778    20,693    5,695          0      3,400
=====
    
```

6. Staff list:

LINE	EMP	NAME	POSITION	FATHER	Active, Drop
1	574	Hesamuddin	Midlevel Dental	Abdul Halim	YES
2	283	M Sadiq	Midlevel Opd	Mohd Hashim	YES
3	580	A Nabi	Guard Day	N/A	YES
4	579	Ab. Rashid	Guard Day	N/A	YES
5	1170	Hatam	Clerk	Ab. Rahman	YES
6	578	Fida Gul	Midlevel Opd	N/A	YES
7	285	A Rahman	Midlevel Opd	Jamaldin	YES
8	297	Fida M	Midlevel Lab	Noor Mohd	YES

Notes:

M C I HEALTH CENTER REPORT

Month 23 FEB 94

Quarter 3, 93

1. Facility:	2. Codes:
Village Malgir	Village 02303700
District Nahre Sarai	MCD Code 02303
Province Helmand	
Party Hezbi-E-Islami (Khalis)	MCI # 73
Commander Hafizullah Khan	Funder USAID

3. Statistics:

Level/Type C-2
 Start date 13 MAR 88
 Planned close date 31 OCT 93
 Services E K L

4. Last Monitored: 20 JUN 93

Last Medical Supply: 10 JUL 93

JAN/JUL	FEB/AUG	MAR/SEP	APR/OCT	MAY/NOV	JUN/DEC
0	0	13,368	3,728	7,456	963
2,765	0	14,912	0	0	

6. Staff list:

LINE	EMP	NAME	POSITION	FATHER	Active	Prop
1	479	Ahmad Jan	Midlevel Dental	Abdullah	YES	
2	480	Abdul Ghafor	Midlevel Lab	Mohd Amin	YES	
3	481	Mira Jan	Midlevel Opd	Mir Hamza	YES	
4	482	Fazal Mohd	Clerk	N/A	YES	
5	484	Gul Ahmad	Guard Day	N/P	YES	
6	488	A. Rahman	Sweeper	N/A	YES	
7	478	Agha Mohd	Nurse	Abdullah	YES	

Notes:

165

M C I HEALTH CENTER REPORT III

Month 23 FEB 94

Quarter 3, 93

1. Facility:

Village Tangay
 District Kajaki
 Province Helmand
 Party Harakat (Mohsani)
 Commander Mula Ghafar

2. Codes:

Village 02306700
 MCD Code 02306
 MCI # 116
 Funder USAID

3. Statistics:

Level/Type C-2
 Start date 26 JUN 90
 Planned close date 31 OCT 93
 Services B E

4. Last Monitored: 12 MAR 93

Last Medical Supply: 15 AUG 93

JAN/JUL	FEB/AUG	MAR/SEP	APR/OCT	MAY/NOV	JUN/DEC
0	19,709	0	8,979	0	0
0	0	20,951	0	0	

6. Staff list:

LINE	EMP	NAME	POSITION	FATHER	Active/Drop
1	1218	Mohammed Basir	Vaccinator	Mohammed Qasim	02 MAY 71
2	591	A Rahman	Sweeper	N/A	YES
3	589	Lal Mohd	Guard Day	N/A	YES
4	858	Hayat Khan	Bhw First Aid	Hayatullah	YES
5	857	Sardar Mohd	Bhw First Aid	Agha Jan	YES
6	587	A Khaliq	Clerk	N, A	YES
7	805	Abdul Zahir	Midlevel Opd	Abdul Rashid	YES

Notes:

166

MCI HEALTH CENTER REPORT

Month 23 FEB 94

Quarter 1, 93

1. Facility:

Village Faisang
 District Baghran
 Province Helmand
 Party Jamiat-E-Islami (Rabbani)
 Commander Abdul Wahid

2. Codes:

Village 02312702
 MCD Code 02312
 MCI # 104
 Funder USAID

3. Statistics:

Level/Type C-2
 Start date 20 JUL 89
 Planned close date 31 OCT 93
 Services E K

4. Last Monitored: 07 JUN 93

Last Medical Supply: 01 FEB 93

JAN/JUL	FEB/AUG	MAR/SEP	APR/OCT	MAY/NOV	JUN/DEC
0	27,930	0	0	0	0
0	0	12,624	0	0	

6. Staff list:

LINE	EMP	NAME	POSITION	FATHER	Active, Drop
1	299	Abdul Rahman	Midlevel Dental	Agha Jan	YES
2	298	Mohd Sadiq	Midlevel Opd	Bismellah	YES
3	448	Amir Qalam	Midlevel Opd	Mohd Juma	YES
4	451	Hasti M	Guard Lay	N/A	YES
5	461	Gh Ali	Guard Day	N/A	YES

Notes:

M C I HEALTH CENTER REPORT

Month 23 FEB 94

Quarter 3, 93

```

=====
1. Facility:
Village Garay
District Baghran
Province Helmand
Party Jamiat-E-Islami (Rabbani)
Commander Abdul Wahid

2. Codes:
Village 02312701
MCD Code 02312
MCI # 103
Funder USAID
=====

```

```

=====
3. Statistics:
Level/Type C-2
Start date 20 JUL 89
Planned close date 31 OCT 93
Services E K L
=====

```

```

=====
4. Last Monitored: 09 JUN 93 Last Medical Supply: 19 JUL 93
=====

```

JAN/JUL	FEB/AUG	MAR/SEP	APR/OCT	MAY/NOV	JUN/DEC
0	22,152	0	94	0	0
14,772	0	20,550	0	0	

6. Staff list:

LINE	EMP	NAME	POSITION	FATHER	Active/Drop
1	287	Abdul Samad	Midlevel Dental	Mohd Hashim	YES
2	533	Abdul Jabar	Guard Day	N/A	YES
3	800	Abdul Salam	Guard Day	N/A	YES
4	286	Sakhidad	Midlevel Opd	Qundal	YES
5	284	Khair Gul	Midlevel Lab	Molah Sherin	YES

Notes:

168

M C I HEALTH CENTER REPORT

Month 23 FEB 94

Quarter 3, 93

1. Facility:
 Village Dara
 District Baghran
 Province Helmand
 Party Jamiat-E-Islami (Rabbani)
 Commander Abdul Wahid

2. Codes:
 Village 02312700
 NCD Code 02312
 NCI # 81
 Funder USAID

3. Statistics:

Level/Type H-3
 Start date 10 NOV 87
 Planned close date 31 OCT 93
 Services A E F G J K L N M

4. Last Monitored: 06 JUN 93

Last Medical Supply: 01 FEB 93

JAN/JUL	FEB/AUG	MAR/SEP	APR/OCT	MAY/NOV	JUN/DEC
0	118,746	0	18,895	5,585	0
95,871	0	82,776	0	33,436	

6. Staff list:

LINE	EMP	NAME	POSITION	FATHER	Active, Drop
1	827	Gh Dastager	Supervisor Ohi	N/A	YES
2	829	Mohd Ayob	Technician	N/A	YES
3	831	Agha Mohd	Technician	N/A	YES
4	830	Zeir Gul	Technician	N/A	YES
5	828	Noor Ali	Technician	N/A	YES
6	884	Jamaludin	Cook	N/A	YES
7	882	Ab Khaliq	Guard Day	N/A	YES
8	431	Mohd Qasim	Doctor	Noor Mohd	YES
9	432	Mohd Yaqub	Supervisor + Admin	Abdul Kabir	YES
10	435	Mudaser	Midlevel Dental	Muhebullah	YES
11	433	Serajudin	Midlevel Lab	Amir Mohd	YES
12	436	Jalaludin	Midlevel Xray	Mohd Shah	YES
13	801	A Hamid	Midlevel Lab	Mohd Sadiq	YES
14	439	Abdul Baqi	Midlevel Opd	Mir Hamza	YES
15	438	Mohd Zia	Midlevel Ward	Qalandar	YES
16	437	Mohd Sadeq	Midlevel Ward	Nezamudin	YES
17	434	Ziaudin	Midlevel Ot	Nasrullah	YES
18	442	Said Mohd	Clerk	N/A	YES
19	443	Piazul Haq	Cook	N/A	YES
20	447	Akhi Dad	Guard Day	N/A	YES
21	446	Jalaludin	Guard Day	N/A	YES
22	445	Rahmudin	Guard Day	N/A	YES
23	444	A. Manan	Guard Day	N/A	YES
24	441	Lal Jan	Driver	N/A	YES

Notes:

MCI HEALTH CENTER REPORT ***

Month 23 FEB 94

Quarter 3, 93

1. Facility:

Village Zarin Khail
 District Nawa
 Province Ghazni
 Party Harakat-E-Engelab (Mahamedi)
 Commander Faizul-Haq

2. Codes:

Village 00615017
 MCD Code 00615
 MCI # 75
 Funder USAID

3. Statistics:

Level/Type C-2
 Start date 21 MAR 88
 Planned close date 31 OCT 93
 Services E K L

4. Last Monitored: 10 JUN 93

Last Medical Supply: 10 JUN 93

JAN/JUL	FEB/AUG	MAR/SEP	APR/OCT	MAY/NOV	JUN/DEC
0	0	0	0	0	5,778
4,852	0	30,038	0	0	

6. Staff list:

LINE	EMF	NAME	POSITION	FATHER	Active, Drop
1	809	Isatullah	Midlevel Ward	G. Nabi	YES
2	646	Nezam Khail	Midlevel Dental	Haji Hazrat Ali	YES
3	280	Aktar Mohd	Midlevel Lab	Abudl Qayum	YES
4	644	Faqirullah	Midlevel Head	Mullah Kakar	YES
5	645	Nasibullah	Midlevel Opd	Ahmad Gul	YES
6	647	Abdullah	Clerk	Haji Ahmad Jan	YES
7	650	M Malik	Sweeper	N/A	YES
8	648	A Malik	Guard Day	N/A	YES
9	649	Tareen Khan	Guard Day	N/A	YES

Notes:

M C I HEALTH CENTER REPORT

Month 23 FEB 94

Quarter 3, 93

1. Facility:	2. Codes:
Village Jandah	Village 00610700
District Mogor	MCD Code 00610
Province Ghazni	
Party Harakat (Mohsani)	MCI # 70
Commander A. Manan Haibafi	Funder USAID

3. Statistics:

Level, Type C-1
 Start date 17 JAN 88
 Planned close date 31 OCT 93
 Services A E J K L

4. Last Monitored: 07 JUN 93

Last Medical Supply: 16 SEP 93

JAN/JUL	FEB/AUG	MAR/SEP	APR/OCT	MAY/NOV	JUN/DEC
29,871	0	0	0	0	0
22,434	0	13,584	0	0	

6. Staff list:

LINE	EMP	NAME	POSITION	FATHER	Active, Drop
1	652	Dr. Abdul Bari	Doctor	Rozi Mohd	YES
2	656	Abdul Ahmad	Midlevel Lab	Abdul Wahab	YES
3	875	Khalil Rahman	Midlevel Opd	Mohd Nabi	YES
4	654	Mahtabuddin	Midlevel Opd	Esmael Habib	YES
5	657	Abdul Wadood	Clerk	N/A	YES
6	653	Abdul Hadi Sedeq	Nurse	Haji Mohd Sedeq	YES
7	981	Janan	Cook	Gulab Khan	YES
8	984	Naqebullah	Guard Day	Abdul Hanan	YES
9	983	Rahim	Guard Day	Abdul Ghafar	YES
10	982	Tawoos	Sweeper	Ab. Mohd	YES
11	1052	Abdul Baqi	Epi Vaccinator	Ab. Ghafoor	YES
12	1049	Hamdullah	Epi Vaccinator	Gh. Qader	YES

Notes:

171

MCI HEALTH CENTER REPORT

Month 23 FEB 94

Quarter 3, 93

1. Facility:

Village Koh Gah
 District Lash Jaween
 Province Farah
 Party Nifa
 Commander Burhanuddin

2. Codes:

Village 02111021
 MCD Code 02111
 MCI # 106
 Funder USAID

3. Statistics:

Level/Type C-3
 Start date 27 AUG 89
 Planned close date 31 OCT 93
 Services E

4. Last Monitored: 15 OCT 92

Last Medical Supply: 02 MAR 93

JAN/JUL	FEB/AUG	MAR/SEP	APR/OCT	MAY/NOV	JUN/DEC
0	0	1,306	0	0	0
0	0	0	0	0	

6. Staff list:

LINE	EMP	NAME	POSITION	FATHER	Active/Drop
1	622	Shamsudin	Bhw First Aid	Nooruddin	YES
2	621	Bahauddin	Bhw First Aid	Sharafudin	YES

Notes:

1/2

F M C I HEALTH CENTER REPORT 111

Month 24 FEB 94

Quarter 3, 93

1. Facility: Village Baghi Pul
 District Panjwai
 Province Kandahar
 Party Khalis
 Commander Mamur Guldas

C. Codes:
 Village 02413700
 MCI Code 02413
 MCI # 25
 Funder USAID

3. Statistics:
 Level/Type C-2
 Start date 22 FEB 88
 Planned close date 31 OCT 92
 Services E K L M

4. Last Monitored: 29 JAN 92 Last Medical Supply:

JAN/JUL	FEB, AUG	MAR, SEP	APR, OCT	MAY NOV	JUN, DEC
0	0	0	0	0	0
0	0	0	0	0	0

6. Staff list:

LINE	EMP	NAME	POSITION	FATHER	Active/Drop
1	424	Noor Ali	Cook	N/A	YES
2	425	Mohd Sadeq	Midlevel Opd	Shah Mohd	YES
3	838	Toor Jan	Driver	N/A	YES
4	843	Ab. Gayum	Cook	N/A	YES
5	856	Abdul Hai	Midlevel Opd	Alhtar	YES
6	418	Abdullah	Midlevel Ward	Alhtar Mohd	YES
7	421	Noor Mohd	Midlevel Opd	Abdullah	YES
8	279	Basheer Ahmad	Midlevel Xray	Hayatullah	YES
9	842	Esa Mohd	Midlevel Dental	N/A	YES
10	419	Mir Ahmad	Midlevel Dental	Saleh Mohd	YES
11	1035	Mohd Jamil	Clerk	Ahram Shah	YES
12	430	Esamuddin	Guard Day	N/A	YES
13	840	Ab Karim	Guard Day	N/A	YES
14	428	Sheer Mohd	Guard Day	N/A	YES
15	959	Naimatullah	Guard Day	N/A	YES
16	839	Ahmadullah	Guard Day	N/A	YES
17	416	Abdul Manan	Midlevel Lab	Mir Hamza	YES
18	426	Abdul Hanan	Clerk	N/A	YES
19	5036	5036	5036	5036	14 OCT 81
20	278	Ali Ahmad	Midlevel Ot	Salih Mohd	YES

Notes:

113

M C I HEALTH CENTER REPORT

Month 24 FEB 94

Quarter 3, 93

```

=====
1. Facility:
Village Sang-I-Hesar
District Maywand
Province Kandahar
Party Harakat (Mohsani)
Commander Mula Faizulah

2. Codes:
Village 02414022
MCD Code 02414
MCI # 19
Funder USAID
=====
    
```

```

=====
3. Statistics:
Level/Type C-3
Start date 21 OCT 87
Planned close date 01 OCT 92
Services E
=====
    
```

```

=====
4. Last Monitored: 23 MAR 90
Last Medical Supply: 01 JAN 92
=====
    
```

JAN/JUL	FEB/AUG	MAR/SEP	APR/OCT	MAY/NOV	JUN, DEC
0	0	0	0	0	0
0	0	0	0	0	0

6. Staff list:

LINE	EMP	NAME	POSITION	FATHER	Active, Drop
1	671	Agha Gul	Ehw First Aid	Haji Mohudin	YES
2	672	Abdul Hai	Ehw First Aid	Rustan	YES
3	670	Mohd Naqib Ahmad	Ehw Head	Faizullah	YES
4	5040	5040	5040	5040	18 OCT 81
5	5041	5041	5041	5041	19 OCT 81
6	5042	5042	5042	5042	20 OCT 81
7	5043	5043	5043	5043	21 OCT 81

Notes:

M C I HEALTH CENTER REPORT

Month 24 FEB 94

Quarter 3, 93

```

=====
1. Facility:
Village Aroq
District Khakraiz
Province Kandahar
Party Hezbi-E-Islami (Khalis)
Commander Wahab Khan

2. Codes:
Village 02407019
MCD Code 02407
MCI # 113
Funder USAID
=====
    
```

```

=====
3. Statistics:
Level/Type C-2
Start date 22 JUN 90
Planned close date 30 MAY 93
Services E K L
=====
    
```

```

=====
4. Last Monitored: 03 JUN 93
Last Medical Supply: 01 NOV 92
=====
    
```

JAN/JUL	FEB/AUG	MAR/SEP	APR/OCT	MAY/NOV	JUN/DEC
2,533	953	0	2,123	0	0
0	0	0	0	0	0

6. Staff list:

LINE	EMP	NAME	POSITION	FATHER	Active/Drop
1	802	M Nadir Shah	Midlevel Dental	Bahawadin	YES
2	803	M Gasim	Midlevel Lab	Mohd Sadiq	YES
3	780	A. Raziq	Clerk	N/A	YES
4	778	Mohd Ashraf	Ehw Head	Mohd Younas	YES
5	782	Sali Mohd	Guard Day	N/A	YES
6	784	A Wahab	Sweeper	N/A	YES

Notes:

HEALTH CENTER REPORT

Month 24 FEB 94

Quarter 3, 93

```

=====
1. Facility:
Village Mana
District Maruf
Province Kandahar
Party Ittehad-E-Islami (Sayyaf)
Commander Mula Ghulaz Mohd

2. Codes:
Village 02416700
MCI Code 02416
MCI # 11
Funder USAID
=====
    
```

```

=====
3. Statistics:
Level/Type C-2
Start date 30 APR 87
Planned close date 31 DEC 92
Services E K L
=====
    
```

4. Last Monitored: 18 MAY 93 Last Medical Supply: 01 SEP 92

```

=====
JAN/JUL    FEB/AUG    MAR/SEP    APR/OCT    MAY/NOV    JUN/DEC
5,780      0          25,830     0          0          0
0          0          0          0          0
=====
    
```

6. Staff list:

LINE	EMP	NAME	POSITION	FATHER	Active/Drop
1	816	Sardar Mohd	Midlevel Dental	Dost Mohd	YES
2	815	Baridad	Midlevel Lab	Khudaly Rahm	YES
3	814	Abdul Malik	Midlevel Opt	Sardar	YES
4	813	Abdul Khaleq	Nurse Head	Mohd Jan	YES
5	362	Mohabullah	Clerk	N/A	YES
6	817	Alizai	Guard Day	N/A	YES
7	819	Rasoul Jan	Sweeper	N/A	YES
8	5006	5006	5006	5006	14 SEP 81

Notes:

HEALTH CENTER REPORT

Month 24 FEB 94

Quarter 3, 93

1. Facility:

Village Zeer Koh
 District Shindand
 Province Farah
 Party Jamiat-E-Islami (Rabbani)
 Commander Mulla Ghani

2. Codes:

Village 02103700
 NCD Code 02103
 MCI # 102
 Funder USAID

3. Statistics:

Level/Type C-2
 Start date 25 APR 89
 Planned close date 31 DEC 92
 Services E K L

4. Last Monitored:

Last Medical Supply: 01 MAR 92

JAN/JUL	FEB/AUG	MAR/SEP	APR/OCT	MAY/NOV	JUN/DEC
0	0	0	0	0	0
0	0	0	0	0	0

6. Staff list:

LINE	EMP	NAME	POSITION	FATHER	Active/Drop
1	569	Mohd Mobin	Midlevel Lab	Mohd Kabir	YES
2	568	Mir Ahmad	Midlevel Dental	Yar Mohd	YES
3	567	Abdullah	Midlevel Opd	Abdul Hamid	YES
4	570	Mir Ahmad	Clerk	N/A	YES
5	573	Noor Ahmad	Guard Day	N/A	YES
6	572	A Alaf	Guard Day	N/A	YES
7					

Notes:

M C I HEALTH CENTER REPORT

Month 24 FEB 94

Quarter 3, 93

1. Facility:

Village Gardi Bagh
 District Arghandab
 Province Kandahar
 Party Jamiat-E-Islami (Rabbani)
 Commander Mamur Guldad

2. Codes:

Village 02413701
 MCD Code 02412
 MCI # 100
 Funder USAID

3. Statistics:

Level/Type C-2
 Start date 25 JUN 89
 Planned close date 31 DEC 92
 Services E K

4. Last Monitored: 09 JUL 92

Last Medical Supply: 01 JUN 92

JAN/JUL	FEB/AUG	MAR/SEP	APR/OCT	MAY/NOV	JUN/DEC
6,261	0	0	0	4,332	0
0	0	0	0	0	0

6. Staff list:

LINE	EMP	NAME	POSITION	FATHER	Active/Drop
1	562	Isa M	Clerk	N/A	YES
2	546	Sayed Rasol	Midlevel Opd	Sardar Mohd	YES
3	564	Shah M	Guard Day	N/A	YES
4	563	A Samad	Guard Day	N/A	YES
5	566	Niaz M	Sweeper	N/A	YES
6	927	Said Mohd	Midlevel Opd	Yar Mohd	YES
7	561	Khairullah	Midlevel Dental	Habibullah	YES

Notes:

M C I HEALTH CENTER REPORT

Month 24 FEB 94

Quarter 3, 93

1. Facility:	2. Codes:
Village Chardar	Village 02705700
District Ghore Taywara	MCD Code 02705
Province Ghor	
Party Harakat (Mohsani)	MCI # 6
Commander Mula Ahmad	Funder USAID

3. Statistics:

Level/Type C-2
 Start date 30 APR 87
 Planned close date 31 JAN 93
 Services E K L

4. Last Monitored: 31 MAY 92 Last Medical Supply: 01 AUG 92

JAN/JUL	FEB/AUG	MAR/SEP	APR/OCT	MAY/NOV	JUN/DEC
0	0	0	0	21,875	0
0	0	0	0	0	

6. Staff list:

LINE	EMP	NAME	POSITION	FATHER	Active, Drop
1	627	Mohd Yusuf	Midlevel Lab	Mohd Younus	YES
2	624	Noor Ahmad	Midlevel Qrd	Ataullah	YES
3	626	Abdul Qadir	Midlevel Dental	Abdul Gayum	YES
4	623	Mahmood	Midlevel Qrd	Taj Gul	YES
5	625	Mohd Zubair	Midlevel Ward	Ghulam Bastagir	YES
6	629	Shamsul Haq	Guard Day	N/A	YES
7	630	M Musa	Sweeper	N/A	YES

Notes:

M C I HEALTH CENTER REPORT

Month 24 FEB 94

Quarter 3, 93

1. Facility:

Village Khwaja Mulk
 District Arghandab
 Province Kandahar
 Party Hembi-E-Islami (Hakawatyar)
 Commander Capt. Jalil

2. Codes:

Village 00412012
 MCI Code 02412
 MCI # 77
 Funder USAID

3. Statistics:

Level/Type C-2
 Start date 27 MAR 88
 Planned close date 30 JUN 93
 Services E K L

4. Last Monitored: 09 JUL 92

Last Medical Supply: 01 DEC 92

JAN/JUL	FEB/AUG	MAR/SEP	APR/OCT	MAY/NOV	JUN/DEC
0	0	13,798	0	0	11,826
8,688	0	0	0	0	

6. Staff list:

LINE	EMP	NAME	POSITION	FATHER	Active/Drop
1	617	Janan	Guard Day	N/A	YES
2	616	Ghulam Mohd	Midlevel Dental	Ghulam Rasool	YES
3	615	Abdul Samay	Midlevel Lab	Abdul Nabi	YES
4	1010	Mohd Naseer	Midlevel Opt	Abdul Gadoos	YES
5	457	Hafizullah	Clerk	N/A	YES
6	618	Ghausuddin	Guard Day	N/A	YES

Notes:

1/8

MCI HEALTH CENTER REPORT

Month 24 FEB 94

Quarter 3, 93

1. Facility:

Village Suzni
 District Shah Wali Kot
 Province Kandahar
 Party Mahaz-E-Milli (Gailani)
 Commander Ata Mohd

2. Codes:

Village 02415700
 MCI Code 02415
 MCI # 74
 Funder USAID

3. Statistics:

Level/Type C-2
 Start date 09 MAR 88
 Planned close date 01 OCT 93
 Services E K L

4. Last Monitored: 29 APR 92

Last Medical Supply: 01 JUN 92

JAN/JUL	FEB/AUG	MAR/SEP	APR/OCT	MAY/NOV	JUN/DEC
0	0	0	0	0	0
0	0	0	0	0	0

6. Staff list:

LINE	EMP	NAME	POSITION	FATHER	Active/Drop
1	912	Abdul Rashid	Clerk	N/A	YES
2	396	Abdul Shakoor	Guard Day	N/A	YES
3	395	A Ghafar	Sweeper	N/A	YES
4	393	Zafaran	Emr First Aid	Abdullah	YES
5	303	Abdul Mohd	Midlevel Dental	Salih Mohd	YES
6	300	Mohamed	Midlevel Lab	Sardar Mohd	YES

Notes:

MCI HEALTH CENTER REPORT

Month 27 FEB 94

Quarter 3. 93

1. Facility:		2. Codes:	
Village	Qarabagh	Village	00609000
District	Qarabagh	MCT Code	00609
Province	Ghazni	MCI #	87
Party	Hezbi-E-Islami (Khalis)	Funder	USAID
Commander	Shair Gul		

3. Statistics:
 Level/Type C 2
 Start date 07 JUL 88
 Planned close date 30 APR 93
 Services E K

4. Past Monitored: 18 SEP 92 Last Medical Supply: 01 OCT 92

JAN/JUL	FEB/AUG	MAR/SEP	APR/OCT	MAY/NOV	JUN/DEC
0	0	0	0	0	0
0	0	0	0	0	0

6. Staff list:

LINE	EMP	NAME	POSITION	FATHER	.. Live/Drop
1	969	Said Abdul Majeed	Clark	N/A	YES
2	496	Baz Mohd	Midlevel Opd	Akhtar Mohd	YES
3	507	A Khalig	Guard Iay	N/A	YES
4	515	Ghulam Sakhi	Sweeper	N/A	YES
5	495	Azizullah	Nurse Head	Toti	YES
6	498	Abdul Samad	Midlevel Dental	Ghulam Sarwar	YES

Notes:

HR M C I HEALTH CENTER REPORT

Month 27 FEB 94

Quarter 3, 93

1. Facility:

Village Koor Kara
 District Arghandab
 Province Zabul
 Party Khalis
 Commander Ghias-Al-Haq

2. Codes:

Village 02505700
 MCD Code 02505
 MCI # 80
 Funder USAID

3. Statistics:

Level/Type C-2
 Start date 27 MAR 89
 Planned close date 30 JUN 93
 Services E

4. Last Monitored: 15 JUN 91

Last Medical Supply: 01 NOV 92

JAN/JUL	FEB/AUG	MAR/SEP	APR/OCT	MAY/NOV	JUN/DEC
0	2,701	0	0	0	0
0	0	0	0	0	0

6. Staff list:

LINE	EMP	NAME	POSITION	FATHER	Active/Drop
1	471	Mohd Younus	Midlevel Opd	Mohd Nabi	YES
2	474	M. Nabi	Clerk	N/A	YES
3	475	Sardar Mohd	Guard Day	N/A	YES
4	476	A. Wali	Guard Day	N/A	YES

Notes:

123

M C I HEALTH CENTER REPORT

Month 27 FEB 94

Quarter 3, 93

1. Facility:

Village Baldasht
 District Kajran
 Province Oruzgan
 Party Nijat
 Commander Mullah Abdul Haq

2. Codes:

Village 02609700
 MCD Code 02609
 MCI # 8
 Funder USAID

3. Statistics:

Level/Type C-2
 Start date 30 APR 87
 Planned close date 31 JAN 93
 Services E K L

4. Last Monitored:

Last Medical Supply: 01 JUL 92

JAN/JUL	FEB/AUG	MAR/SEP	APR/OCT	MAY/NOV	JUN/DEC
39,390	0	0	0	0	0
0	0	0	0	0	0

6. Staff list:

LINE	EMP	NAME	POSITION	FATHER	Active/Drop
1	824	M Ismail	Midlevel Lab	Khudaidad	YES
2	638	Mohd Umar	Midlevel Dental	Haji Dadullah	YES
3	868	Mir Hatam	Midlevel Opd	Mullah Kaka	YES
4	370	Noor Mohd	Clerk	N.A	YES
5	635	Noor Habib	Enw First Aid	Mohd Rahim	YES
6	367	Amir Din	Guard Day	N.A	YES
7	841	Khaneen	Guard Day	N.A	YES

Notes:

1834

M C I HEALTH CENTER REPORT

Month 27 FEB 93

Quarter 3, 93

1. Facility:

Village Tolak
 District Toulak
 Province Ghor
 Party Jamiat-E-Islami (Rabbani)
 Commander Wakil M. Gaswan

2. Codes:

Village 02704000
 NCD Code 02704
 MCI # 78
 Funder USAID

3. Statistics:

Level/Type C-2
 Start date 27 MAR 88
 Planned close date 31 DEC 92
 Services E K

4. Last Monitored: 02 JUN 92

Last Medical Supply: 01 JUN 92

JAN/JUL	FEB/AUG	MAR/SEP	APR/OCT	MAY/NOV	JUN/DEC
0	0	0	0	0	0
34,584	0	0	0	0	0

6. Staff list:

LINE	EMP	NAME	POSITION	FATHER	Active/Drop
1	398	Wali Mohd	Hw First Aid	Kasaludin	YES
2	400	Mohd Ebrahim	Midlevel Dental	Abdul Rahman	YES
3	399	Ghulam Yahya	Midlevel Opt	Shah Mohd	YES
4	413	M Rafiq	Sweeper	N/A	YES
5	412	Hussian	Guard Day	N/A	YES
6	406	A Majeed	Guard Day	N/A	YES

Notes:

HEALTH CENTER REPORT 110

Month 24 FEB 94

Quarter 3, 93

1. Facility:	2. Codes:
Village Khawchala	Village 02601700
District Tirin Kot	MCD Code 02601
Province Oruzgan	
Party Jamiat-E-Islami (Rabbani)	MCI # 29
Commander Abdul Manan	Funder USAID

3. Statistics:
 Level/Type C-2
 Start date 11 FEB 89
 Planned close date 01 DEC 92
 Services E K L

4. Last Monitored: 22 FEB 94 Last Medical Supply: 01 JUL 92

JAN/JUL	FEB/AUG	MAR/SEP	APR/OCT	MAY/NOV	JUN/DEC
0	0	0	0	0	0
0	0	0	0	0	0

6. Staff list:

LINE	EMP	NAME	POSITION	FATHER	Active, Drop
1	491	Noor Mohd	Clerk	N/A	YES
2	492	M Hashim	Sweeper	N/A	YES
3	493	Mira Jan	Guard Day	N/A	YES
4	487	Fazal Rahman	Midlevel Opd	Yar Mohd	YES
5	489	Turyalai	Midlevel Lab	Mohd Azim	YES
6	489	Ghulam Farooq	Midlevel Dental	Ghulam Mohd	YES

Notes:

131

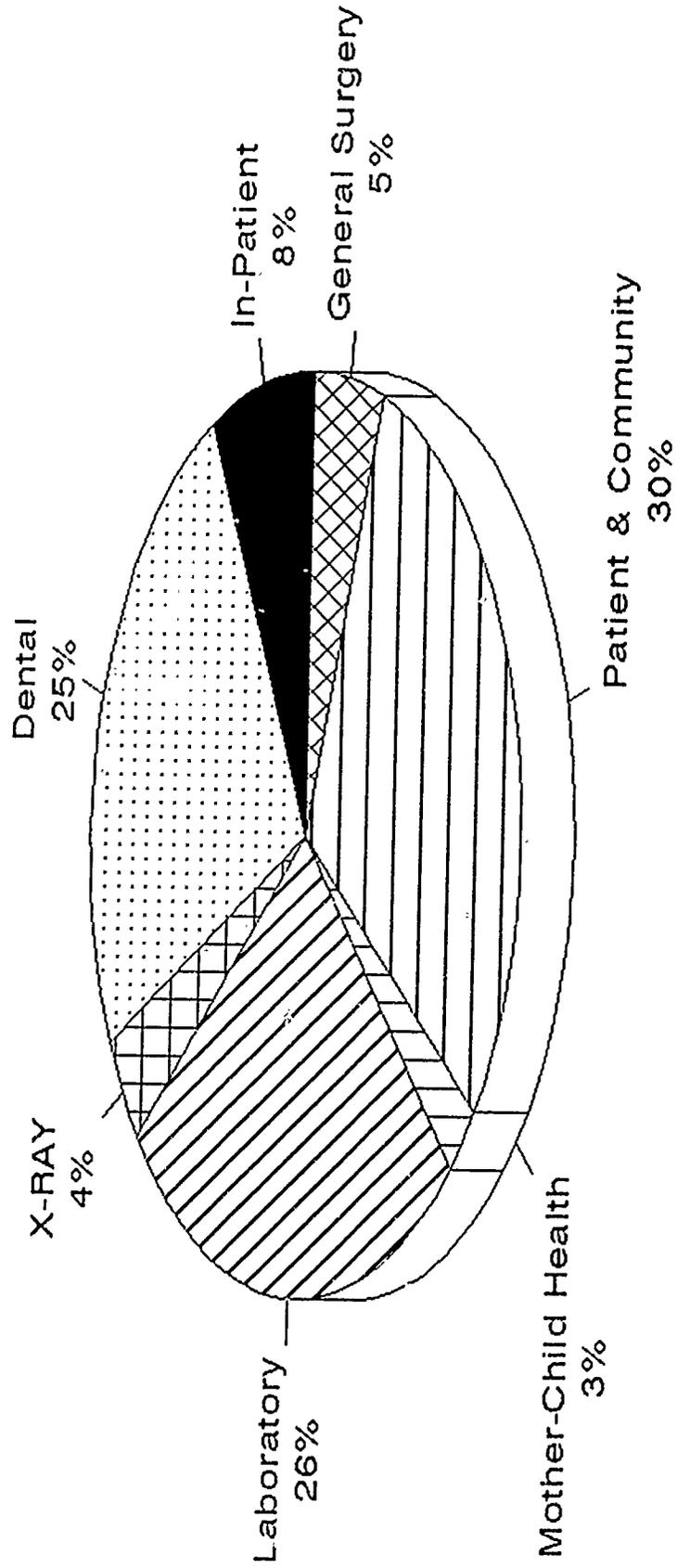
ANNEX 9

CLINICAL ACTIVITIES OF HEALTH FACILITIES IN
AFGHANISTAN

135

Major Services rendered by 25 MCI Clinics

Supported by USAID in South-West Afghanistan



ANNEX 10

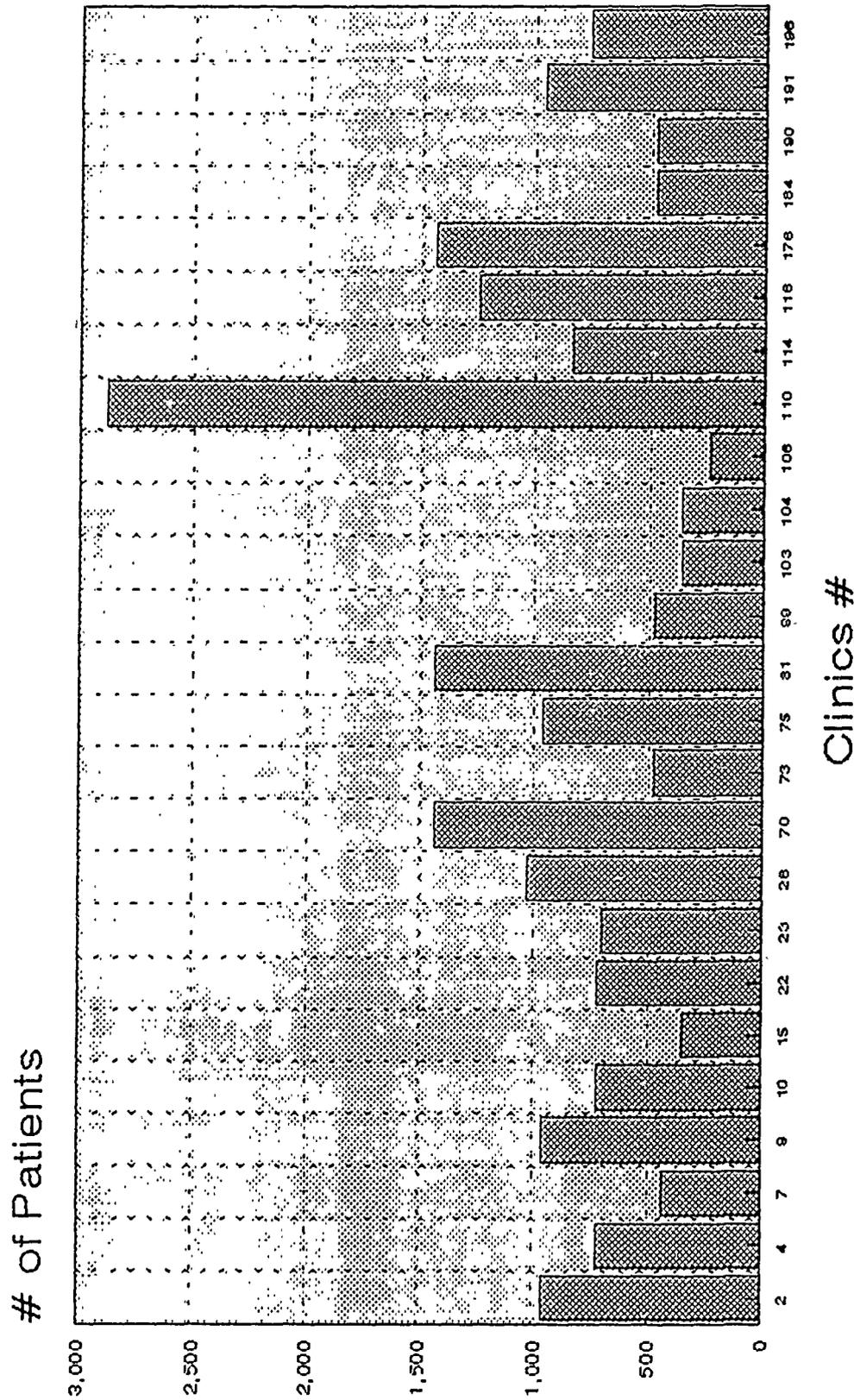
RECORD OF PATIENTS SEEN AT CLINICAL FACILITIES IN

AFGHANISTAN

137

Average Patients Per Month over life of Clinics

MCI Clinics Supported by USAID.



ANNEX 11

CALENDAR OF PHYSICIAN MONITORING OF AFGHANISTAN

CLINIC OPERATIONS

MONITORING REPORT BY PHYSICIANS FOR MCI CLINICS

CLINIC No.	ESTABLISHED	M1	M2	M3	M4	M5	M6	M7	M8
2	JAN 89	DEC 89	JUL 90	JUL 92	MAY 93				
4	JAN 89	JUN 91	JUN 92	JUN 92	JUN 93				
6	APR 87	MAY 92							
7	APR 87	JUN 88	OCT 89	APR 90	AUG 90	MAY 93			
10	JUN 88	JUL 92	MAY 93						
11	APR 87	JUL 89	MAR 90	MAY 92					
15	JUL 87	FEB 90	MAR 90	MAY 93					
16	OCT 87	MAY 90							
17	MAR 88	FEB 90	APR 90						
18	AUG 87	MAR 90	JUL 90						
19	OCT 87	MAR 90							
22	JAN 88	JAN 90	FEB 90	JAN 93					
23	JAN 88	JUN 91	JUN 92	JUN 92	JUN 93				

M1 = 1 st MONITORING, M2 = 2 nd MONITORING M8 = 8 th MONITORING

190

MONITORING REPORT BY PHYSICIANS FOR MCI CLINICS

CLINIC No.	ESTABLISHED	M1	M2	M3	M4	M5	M6	M7	M8
25	JAN 88	FEB 90	MAR 90	JAN 92					
26	MAR 88	FEB 90	APR 90	JUL 90	AUG 90	JAN 92	MAY 92	JUN 92	JUN 93
28	FEB 89	JAN 90	FEB 90						
70	JAN 88	AUG 90	NOV 91	JAN 93					
73	MAR 88	JUL 92	JUN 93						
74	MAR 88	MAR 90	AUG 90	JAN 92	APR 92				
75	MAR 88	AUG 90	NOV 91	JUN 93					
77	MAR 88	MAR 90	AUG 90	JAN 92	APR 92	MAY 92	JUL 92		
78	MAR 88	JUN 92							
80	MAR 88	AUG 90	JUN 91						
87	JUL 88	JUL 90	JUN 92	JUL 92	SEP 92				
99	MAR 89	MAY 92	MAY 93						
100	JUN 89	JUL 92							

M1 = 1 st MONITORING, M2 = 2 nd MONITORING M8 = 8 th MONITORING

191

MONITORING REPORT BY PHYSICIANS FOR MCI CLINICS

CLINIC No.	ESTABLISHED	M1	M2	M3	M4	M5	M6	M7	M8
103	JUL 89	MAY 92	JUN 93						
110	FEB 90	JUN 92	JUL 92	JUN 93					
113	JUN 90	AUG 90	MAY 92	JUN 92					
114	MAR 90	JAN 92	MAY 92	JUN 92	JUN 93				
176	NOV 90	JAN 92	APR 92	JUN 92	MAY 93				
190	NOV 90	JUL 92	JUN 93						
191	MAY 91	JUN 91	MAY 93						
196	MAY 91	JAN 92	APR 92	MAY 93					

M1 = 1 st MONITORING, M2 = 2 nd MONITORING M8 = 8 th MONITORING

192

ANNEX 12

CALENDAR OF PHYSICIAN DEBRIEFING OF AFGHANISTAN

CLINIC OPERATIONS

192

DEBRIEFING REPORT BY PHYSICIANS FOR MCI CLINICS

CLINIC No.	D1	D2	D3	D4	D5	D6	D7	D8	D9*	D10	D11	D12	D13	D14	D15	D16	D17	D18	D19	D20
2	FEB 89	APR 89	JUL 89	OCT 89	JAN 90	MAY 90	APR 92	NOV 92	MAY 93											
4	JUN 90	MAY 91	OCT 91	AUG 92	JUN 93															
6	APR 89	AUG 89	JAN 90	JUL 91*	JUL 91*	JUL 91*	MAY 92	AUG 92												
7	AUG 88	MAR 89	APR 89	JUN 90	MAR 91	MAY 93														
8	OCT 91																			
9	SEP 90*	SEP 90*	SEP 90*	JAN 91	AUG 91	JUL 92	MAY 93													
10	SEP 90*	SEP 90*	JAN 91	JUN 91	NOV 92	MAY 93														
11	DEC 88	MAR 89	AUG 89	NOV 89	MAR 90	JUL 90	MAR 91	AUG 91	MAY 92	JUL 92										
13	MAY 89	JUL 89	NOV 89*	NOV 89*	NOV 89	JUN 90	MAR 91	AUG 91	OCT 91											
14	JUL 90	DEC 90	MAY 91	OCT 91*	OCT 91*															
15	MAR 89	OCT 89	JAN 90*	JAN 90*	JAN 90*	JAN 90*	APR 90	JUL 90*	JUL 90*	JAN 91	JAN 91	JUL 91	JUN 92	MAY 93						
16	MAY 89	NOV 89	MAR 90	DEC 90																
17	OCT 88	FEB 89	APR 89	JUL 89	OCT 89	MAR 90*	MAR 90*	MAR 90*	APR 90	JAN 91*	JAN 91*	SEP 91								

D1 = 1 st DEBRIEFING, D2 = 2 nd DEBRIEFING M20 = 20 th DEBRIEFING
 * Different individuals from the same clinic were sometimes debriefed within the same month

DEBRIEFING REPORT BY PHYSICIANS FOR MCI CLINICS

CLINIC No.	D1	D2	D3	D4	D5	D6	D7	D8	D9	D10	D11	D12	D13	D14	D15	D16	D17	D18	D19	D20
18	JAN 89	AUG 89	FEB 90	JUL 90	MAR 91	MAR 91	MAR 91	JUL 91												
19	FEB 89	MAR 90	SEP 91	SEP 91																
22	FEB 89	JUN 89	JUN 89	OCT 89	FEB 90	JUL 90	DEC 90	JAN 91	MAY 91	OCT 91	JUN 92	NOV 92	JAN 93							
23	SEP 88	NOV 88	NOV 88	DEC 88	APR 89	APR 89	AUG 89	AUG 89	NOV 89	NOV 89	MAR 90	JUL 90	JUL 90	NOV 90	NOV 90	MAR 91	AUG 91	JUN 92	JUN 92	JUN 93
25	OCT 88	JAN 89	JAN 89	APR 89	JUN 89	JUN 89	SEP 89	SEP 89	DEC 89	JAN 90	MAY 90	SEP 90	JAN 91	FEB 91	MAY 91	JAN 92	MAY 92			
26	APR 89	OCT 89	OCT 89	FEB 90	MAR 90	JUN 90	JUN 90	JUN 90	JAN 91	MAY 91	SEP 91	OCT 91	JUN 93							
28	AUG 89	AUG 89	NOV 89	FEB 90	MAY 90	SEP 90	FEB 91	FEB 91	SEP 91	JUN 92										
70	SEP 88	NOV 88	JAN 89	APR 89	APR 89	JUL 89	JUL 89	NOV 89	NOV 89	MAR 90	JUN 90	JUN 90	OCT 90	JAN 91	JAN 91	APR 91	AUG 93	JUN 93		
73	FEB 89	MAY 89	MAY 89	SEP 89	DEC 89	SEP 89	SEP 89	SEP 89	JAN 91	NOV 92	JUN 93									
74	NOV 88	DEC 88	APR 89	AUG 89	SEP 89	OCT 89	DEC 89	MAY 90	AUG 90	FEB 91	JUL 91	JUL 91	APR 92	MAY 92						
75	NOV 88	APR 89	JUL 89	JUL 89	OCT 89	FEB 90	JUN 90	NOV 90	NOV 90	MAR 92	JUL 92	JUN 93								
77	NOV 88	JAN 89	MAY 89	SEP 89	OCT 89	DEC 89	FEB 90	JUN 90	JUN 90	NOV 90	MAY 91	JUN 92	JUL 92							
78	JAN 89	OCT 89	AUG 90	AUG 90	JUN 91	JAN 92	JUN 92													

D1 = 1 st DEBRIEFING, D2 = 2 nd DEBRIEFING M20 = 20 th DEBRIEFING
 * Different individuals from the same clinic were sometimes debriefed within the same month

195

DEBRIEFING REPORT BY PHYSICIANS FOR MCI CLINICS

CLINIC No.	D1	D2	D3	D4	D5	D6	D7	D8	D9	D10	D11	D12	D13	D14	D15	D16	D17	D18	D19	D20
80	DEC 88	SEP 89*	SEP 89*	NOV 89	MAR 90	JUN 90	APR 91	JUN 91												
81	SEP 88	FEB 89	MAR 89	JUL 89	AUG 89	NOV 89	MAY 90*	MAY 90*	MAY 90*	SEP 90	OCT 91	JUL 92	JUN 93							
87	MAY 89	AUG 89	DEC 89*	DEC 89*	SEP 90	NOV 91	SEP 92	OCT 92												
99	JUN 90	DEC 91	JUL 92	MAY 93																
100	APR 91	JUL 92																		
102	SEP 90	MAR 92																		
103	DEC 89	MAY 90	JUL 92	JUN 93																
104	DEC 89	MAY 90	SEP 90	JUL 92	JUN 93															
106	FEB 90	DEC 91	OCT 92																	
110	FEB 90	MAY 90	AUG 90	NOV 90	APR 91	MAR 92	JUN 93													
113	MAR 91*	MAR 91*	SEP 91	JUN 92																
114	MAR 90	JUN 92	JUN 93																	
116	OCT 91	JUN 92	MAR 93																	

D1 = 1 st DEBRIEFING, D2 = 2 nd DEBRIEFING M20 = 20 th DEBRIEFING
 * Different individuals from the same clinic were sometimes debriefed within the same month

198

ANNEX 13

CHRONOLOGY OF MEDICAL ACTIVITIES INSIDE AFGHANISTAN

&

SUPPORTING WAREHOUSE AND SUPPLY ACTIVITIES 1986 -1993

198

ANNEX 13CHRONOLOGY OF MEDICAL ACTIVITIES IN AFGHANISTAN and SUPPORTING WAREHOUSE AND SUPPLY ACTIVITIES 1986 -1993**1986**

*Five fixed clinics and 6 mobile units established inside Afghanistan

1987**First quarter**

*Fact finding mission Dec 18-Feb 22 1987 by Engineer Ayubi and Mr. Farouq to assess medical needs in Kandahar, Rozgan, Helmand, Ghorat, and Herat found that the needs were not uniform: some areas with heavy fighting needed surgical services, while quieter areas were more in need of OPD services. Defined several levels of service: Surgical clinics, Level A and Level B OPDs, Mobile units, and First aid workers. Developed a plan to establish a total of ~36 facilities over next year.

Second quarter

*Salaries of clinic workers decided based on CMC standards

*Plans to review graduates work once they are established inside under actual working conditions every 3 months (in addition to oral, written and practical exams done in Quetta during training course)

*Established a surgical hospital plus 3 mobile units in Herat, established 1 level A OPD and 1 level B OPD in Ghorat, established 2 level B OPD units in Farah (held up at border), upgraded the surgical hospital and established a level B OPD in Helmand, and established 1 level A OPD and 1 level B OPD in Rozgan. No activities in Kandahar because of fighting.

*Overall, established 11 health care centers and 8 mobile units in selected locations in Afghanistan

Third quarter

*reviewed reporting requirements with the inside clinics: need for documentation of activities, supply use, personnel, and political/local events of importance

Fourth quarter

*Reports received from clinics inside: found one of MCI clinics also receiving support from private organization in Peshawar

*Drug list revised- meetings of CMC (Swedish Comm made list)

*Ordering/supplies/inventory of drugs all computerized

*Difficulties receiving shipments through customs at Karachi

1988**First quarter**

*Continued problems with communications from inside centers

149

*Further development of monitoring systems for inside operations: divided SW Afghanistan into 15 monitoring unit districts, and will identify a "contact person" in each area to provide unofficial reports on clinic activities; also some monitoring to be done at the border

*CMC developed standardized arrangements for monitoring (MSH, IMC, CMC); plan cooperative monitoring trip with Swedish Committee.

*Reorganization of warehouse computer system; new warehouse supervisor hired Hans Karlsson

Second quarter

*Difficulties with route permits for border area

*Inside clinics: continued problems receiving reports. Notified all clinics that receipt of reports a condition for continued funding. All Kandahar district clinics sent reports this quarter

*"Destroyed" motorcycles replaced with bicycles

*Problems setting up clinics due to commanders, floods, students refusing to return to Afghanistan

*Some clinics sent excellent reports, and monitoring showed operations proceeding well

*Established 3 new surgical clinics and 6 more OPD units. By August, will have 7 additional OPD units and 1 more surgical clinic. 1 surgical clinic and 4 OPD units from last year were transferred to new locations

*Supplied 5 surgical clinics, 14 OPD units, 10 mobile units, and 200 first aid workers with a total of \$375,442 supplies and equipment, and \$201,945 in operating costs

*Established a detailed monitoring plan for all inside centers, first aid workers. 30% of plan was activated by May 31, 1988

Third quarter

*Problems with medical shipments

*Cooperated with AMI regarding plans to monitor MCI clinics

Fourth quarter

*Difficulties with road permits; waited for 14 months to get shipment from Pakistan customs

*Inside activities: monitoring trips assessed the function of clinics. Some of the MCI trained health workers told the monitors that the supervising doctors were not practicing according to standards of care. Investigation of these cases led to closer supervision of some the doctors, and in one case, a doctor was terminated

*AMI sponsored monitoring trip was cancelled by Pakistani officials at the border

*Negotiations with SCA about supplying medicines to MCI clinics

*Conducted a complete review of standard supply lists

1989**First quarter**

- *Continued difficulties with transport across Pak/Afg border
- *Bombing of Rozgan; one clinic damaged
- *Monitoring found unsafe medical practices in 2 clinics, one was down-graded, the other was closed
- *Monitoring of 10 clinics by MCI nontechnical staff or MSF medical monitors
- *Extensive debriefing activities including BHWs in Quetta
- *Plans for 8 new OPDs as MCI moves out of Herat area (too far to monitor, also some redundancy); 3 begun as mobile units in Nimroz and Farah, Helmand, Zabul
- *24 facilities resupplied
- *4 monitoring trips

Second quarter

- *Received permission from Pakistan government to move supplies across border
- *Completely withdrawn from Herat: set up 5 new clinics
- *Resupplied and debriefed 33 clinics
- *Monitoring of 36 medical facilities
- *MAP shipment destined for MCI traced to GOP
- *O/AID/REP assisted with obtaining route permit -worked well
- *Upgraded 7 clinics

Third quarter

- *Continued work on 8 new clinics transferred out of Herat; one started in Farah as mobile unit and received first supply
- *Conducted monitoring in 6 provinces
- *Trained 2 technical monitors; very successful
- *Continued difficulty with receipt of MAP shipments through Pakistan customs
- *Re-categorized existing clinics
- *Conducted monitoring in 5 provinces, 15 facilities
- *Debriefed 24 facilities
- *Ambush of medicines, motorcycle, spare parts in Nimroz-supplies for Mobile Unit in Farah - all lost to government troops
- *Expatriate Olive Fast began to help in warehouse

Fourth quarter

- *Conducted extensive monitoring inside Afghanistan using both technical and nontechnical monitors
- *Resupply of 25 clinics
- *2 facilities transferred from Herat now operational in Helmand
- *28 clinics monitored, 25 debriefed, 35 BHWs debriefed

1990**First quarter**

- *Inside: 20 facilities were resupplied with items purchased locally

*MAP medicines delayed in Islamabad arrived
 *Monitoring trips focuses on performance review in 17 clinics

Second quarter

*Medicine inventory was computerized
 *Joelle DuBois, nurse midwife, Belgian, agreed to evaluate outreach worker program operating out of Baghran hospital
 *Debriefing of returning health workers: 37 this quarter (2-3/d, each session 2-3 hrs).
 *Added debriefing sessions for dental and lab workers using written oral and practical exams
 *16/39 facilities were monitored: all but one was active
 *Arranged for independent monitoring by ICRC physicians based in Kandahar
 *Continued upgrade of warehouse computer system with assistance of various expatriates
 *Resupplied 29 facilities
 *Restricted resupply to MCI-registered first aid workers only

Third quarter

*Complete review of monitoring system; departure of Mr. Farouq with many of his followers
 *Changed designati. of MCI clinical facilities in Afghanistan to conform with WHO terminology
 *Installed new warehouse inventory computer system

Fourth quarter

*Dr. Imam appointed head of clinical services in Afghanistan
 *Mr. Aman appointed head of warehouse
 *Initiated plan to reduce waste of supplies and pharmaceuticals due to poor distribution

1991

First quarter

*Held meetings with commanders and health committees inside Afghanistan to improve acceptance of MCH activities at MCI health clinics
 *Reduced expenses for inside workers by ~50%
 *Monitoring trip by Dr. Agha Mohammed Feb 22- Mar 9 to inspect flood damage, and to visit Dand, Arghandab, Arghistan, Maiwand
 *Monitoring trip by Dr. Imam 27 Feb- 22 Mar to Nimroz, Farah: serious flood damage in Shindand, Lash Jawin
 *Modified procedures for on-site debriefing and monitoring resulted in improved assessments of the abilities of health workers and identification of ongoing problems. Used this forum to provide "on the spot" refresher
 *Distributed goods to flood victims in Maiwand, Panjwai, and Arghandab districts

206

Second quarter

*Conducted site visits to inside clinics to review drug stocking protocols

*Monitoring trip by John Mitchell and Dr. Zia to Kandahar and Helmand late April; construction monitoring trip early June to Ghazni; also monitoring in June with WHO to Zabul

*Continued construction work on WHO funded clinics

*Began TB outreach/treatment program in Baghran

Third quarter

*All medical activities inside Afghanistan suspended by USAID: no supplies given

*Fee for service started in Moqor (Ghazni)

*Warehouse started to receive supplies from MSH as part of initial steps in combined procurement system

Fourth quarter

*Suspension of medical activities inside Afghanistan sustained: no supplies, no monitoring or supervision or other cross border activities

*Trips to Ghazni (Nov 5-10) & Kandahar (Nov 26-29) to redistribute clinic supplies to areas of intense fighting and to assist in negotiations related to the kidnapping of U.S. citizens

*Suspension lifted December 29th

*Received first RONCO/MSH combined procurement shipment

1992**First quarter**

*50% of clinics returned for resupply; continued trouble with Pakistan road permits

*Monitoring by Dr. Kher Ahmad and Dr. Mohsin Jan 6-Feb 1, by Dr. Imam, Dr. Anwar Omar, Abdul Qader, and Assadullah Feb 25-Mar 3, and by WHO (Dr. Lipp)

*Procurement of medical supplies halted in March

Second quarter

*Completed standardization of salaries of inside workers

Third quarter

*Implemented new salary scales at inside clinics: reduced salaries by 50%, discontinued benefits (food, generator supplies, motorbike fuel) and instituted fee for service at most clinics

*Clerks from inside observed fee collection procedures at Al-Jehad

*Discontinued local purchase of medical supplies, expanded use of combined procurement system

*Monitoring trips to Kandahar July 24-28

*Monitoring to Kandahar to observe construction Aug 23, talk to Mirwais Hospital

*nearly 100% of supplies from combined procurement system, delay in receipt of some items as long as 8 weeks from MSH

*received directive from USAID to close Bagh-I-Puhl facility

Fourth quarter

*Received list of redundant clinics inside from USAID (23 out of 39); directed to close all but 21

*Established plans for common kit system (CKS)

*Monitoring: Oct 7-8 in Kandahar, Dec 16-17 with Doug Palmer (USAID Health Programs Officer), plus all clinics in Kandahar, Zabul, Ghazni, 2 in Urozgan, 1 in Helmand

1993

First quarter

*Phase-out of redundant clinics was begun, leaving a total of 25 assisted clinics

*All supplies for CKS shipped to MSH/Peshawar; inventory of remaining material

*Material shipped to Mir Wais Hospital in Kandahar for training programs

*Monitoring: Jan 11-13 and Mar 10-18 Mir Wais

*Mir Wais Construction: Jan 27-Feb 4, Feb 25-Mar 3, and Mar 28-Apr 20

Second quarter

*Met with representatives from 19 of remaining 25 supported clinics about phase-out plan

*Debriefing operations conducted by Kandahar-based training staff

*Reviewed remaining inventory in warehouse to prepare final distribution plans

Third quarter

*Plans to distribute remaining kits to Afghanistan health facilities

*Monitoring continues; assistance in final transitions to fee-for-service

Fourth quarter

*All inside activities discontinued October 31 as scheduled

204

ANNEX 14

CHRONOLOGY OF ADMINISTRATIVE ACTIVITIES AND

EXPATRIATE SUPPORT 1986-1993

205

ANNEX 14
CHRONOLOGY OF ADMINISTRATIVE ACTIVITIES AND EXPATRIATE SUPPORT
1986-1993

1986

- *July 1, 1986: Medical Help project signed
- *Developed an administrative unit in Quetta
- *Congressional delegation and USAID projects officer visited Quetta

1987

First quarter

- *Jerry Dines visited Portland
- *MCI VP visited Quetta
- *MCI reported to AID Projects Officer
- *Board meeting held
- *First medical volunteer Nancy Jo Hoover, Lab Tech arrived
- *Beverly Knight, a nurse practitioner, arrived to upgrade nursing standards at Ansari
- *Tessa Fenrich RN from Staff college worked with surgery students
- *After review of practices at Ansari Hospital, MCI decided to terminate agreement with Ansari and to investigate Al-Jehad for possible collaboration

Second quarter

- *Obtained official recognition for MCI from Government of Pakistan
- *MCI president visited Quetta
- *Tom and Janet Nygren arrived as Administrative and Training Coordinators
- *Board of Directors meetings held twice
- *Beverly Knight departed; Helen Murray, nurse, replaced her to coordinate curriculum
- *Attempted to resolve the many difficulties of dealing with the 7 main political parties: obtaining a consensus, and devising a method so that good potential students not sponsored by political parties could be introduced to MCI

Third quarter

- *Visits from USAID evaluators: Dr. Pamela Hunte, Delores Angleton (Nurse), and Sharon Pines-Benoliel (USAID evaluator).
- *Clarification of relationship between Al-Jehad, commanders, MCI
- *Dr. Arthur Jaucian, Phillipines, hired as hospital administrator
- *Janice Jespersion hired as MCH nurse
- *Edith Genova, nurse from Phillipines, hired
- *Lab manual developed by Nancy Jo Hoover, lab technician
- *Developed local personnel policies for Al-Jehad employees

*Established organizational structure of Al-Jehad Training Hospital

Fourth quarter

- *MCI joined Coordination of Medical Committees in September
- *Helen Murray returned to U.S
- *Nurse Edith Genovea arrived from Phillipines but returned because of medical emergency after 2 weeks
- *Visits from Dr. Robert Dunlap, Medical Director United Christian Hospital Lahore & by Chinese delegation
- *Negotiation with Board of political parties about personnel issues (tried to politicize; MCI refused)

1988

First quarter

- *Met with Dr. Scherrer-Palma (AID representative) to review activities
- *Mella Leiter, nurse, began as Health Training Coordinator in January
- *Temporary Hospital nursing coordinator found (2 positions: training and nursing supervisor)
- *Short term lab tech, Mary Patricia Hickey, arrived for 1 month; replaced by Joseph Aires from Phillipines
- *Dr. Roger Durand, from Australia, hired part-time to help with training
- *Discussions with MSH about collaboration in training efforts
- *CMC meetings continued regularly

Second quarter

- *President of MCI visited Quetta
- *CD and Afghan Coordinator met with USAID representative in March and May
- *Discussions continued with CMC in Peshawar
- *Biweekly staff meetings continued
- *Board of directors meetings were less often, fewer issues to discuss
- *Helen Koester arrived as Nursing Coordinator
- *Dr. Arthur Jaucian took on responsibilities as Medical Center Administrator
- *Myron and Janice Jespersen depart
- *Local hire expatriate assumes positions as MCH coordinator

Third quarter

- *Many journalists reporting on Kandahar situation visited MCI
- *Met with IMC regarding possible airlifting of injured mujahadeen
- *Attended meetings with Aide Medicale Internationale (AMI), World Vision, UNICEF, WHO, ACBAR, SWABAC, UNHCR, and CMC
- *Biweekly staff meetings

- *CD to Portland
- *CD and Afghan Coordinator met with AID/REP Projects Officer
- *New staff house rented and furnished
- *American nurse, Vera McArthur, hired as Nursing Instructor
- *Dr. Elmer Pedregosa from Phillipines to help with clinical teaching

Fourth quarter

- *Board meeting end of November
- *Biweekly staff meetings
- *Proposal to move out of Herat as duplication and too far to monitor
- *CD reported regularly to O/AID/REP; monthly with AID projects officer and AID/REP
- *Attended ACBAR, SWABAC, CMC, and UN Coordinators meetings
- *Completed translation of WHERE THERE IS NO DENTIST for Health Education Resource Center in Peshawar 4th quarter 1988
- *Visited by US Embassy Afghan envoy, & Chief of Afghan Refugee Affairs, O/AID/REP, MAP, World Relief, Refugees International Japan, WHO, NOVIB [Dutch semi-governmental organization], UNILOG, Dutch embassy counselor, representatives from Japanese embassy, Chief Commissioner for Afghan Refugees, IMC
- *Lab technician Joseph Aires suddenly requested by Pak govt to leave country
- *Dawn David, a physician's assistant arrived for 1 year contract
- *Oral health group visited: dental surgeon, dental hygienist, and nurse wrote up curriculum for dental rotation for AMA course
- *Continued problems obtaining visas for expatriates
- *Japanese nurse and local expatriate assisted at MCH clinic

1989

First quarter

- *Renewed Project Agreement with USAID for 1989-1990
- *CD and Director of Inside Operations to Portland
- *Executive committee formed: key Afghan and expatriate staff
- *Ongoing meetings and cooperation with other agencies: ACBAR, SWABAC, CMC, UNHCR committees on repatriation, MSH
- *Meetings with SCA: re: possible contract for SCA to supply some MCI clinics
- *Meetings with Intergovernmental Committee for migration (ICM) re: recruitment of Afghan doctors from Germany to work in Pakistan
- *2 new expatriate volunteers for x-ray and dental services
- *Met with UNDP, UN Volunteers, Geneva liaison for SWABAC and ACBAR
- *Met with USAID representatives
- *Extensive meetings with staff re: salary differentials (presence of ICRC and UN agencies offering higher salaries made

258

it difficult to keep the best workers)

Second quarter

*Visits from Portland Headquarters of program and finance directors

*US Ambassador to Pakistan visited

*Cooperation with ACBAR, SWABAC, CMC

*Meetings with AICF re: distribution of donated medicines

*Meetings with AVICEN re: immunization procedures

*Meetings with German Afghanistan Committee re: distribution of donated medicines

*Meetings with MSH re: transfer of MCI Herat clinics

*Meetings with SCA re: coordination of warehouse, transport of supplies

*Cooperated with CMC for monitoring of inside operations

*Hospital Nursing Coordinator Helen Koester returned home

*General Course Instructor, Vera McArthur, returned home

*Pam Odhiambo replaced Nursing Coordinator

*An American medical student volunteered for one month

*Chairman of the Board of MCI met with Benazir Bhutto, Dan Quayle, Ambassador Oakley

*Multiple meetings with Swiss Human Rights Group, correspondants for Reuters, British Agencies Afghan Group, Food for Peace Refugee Affairs US Embassy, US Embassy Envoy for Afghanistan, WHO, UNOCA, French Journalist, BBC Pushto Service

Third quarter

*Jerry Dines, CD to Portland

*ACBAR, SWABAC, and CMC meetings continued

*Discussions with MSH, SCA, OHI, ICM

*Tom Nygren and Janet Nygren (administrative and monitoring coordinators) returned home, Kate and Jon Mitchell replaced them

*Dental trainer Tess Ladrillo recruited, Lab tech Alicia Tanpua recruited

*Meetings with UNESCO, ICM, USAID Rep, State Department Assistant Secretary of State, State Department, SCA, WHO, UNOCA, Farah Reconstruction Foundation

*USAID medical technologist Carol Phillips visited Al-Jehad lab

Fourth quarter

*Threat against expatriate women at Al-Jehad; 3 spent 1 week in Islamabad

*MCI VP of International Programs, Bill Essig, visited Quetta

*Meetings with USAID evaluation team

*Meetings with ACBAR, SWABAC, CMC

*Meetings with IOM (formerly ICM) about screening patients for treatment abroad

*Meetings with WHO, OHI, MAP, Shelter Now International, Austrian Refugee Committee, National Islamic Front of Afghanistan, SCA, AICF [collaborated on training outreach

workers]

- *Nursing coordinator left, Afghan nurse took over
- *Alice Tanpua and Tess Ladrillo arrived
- *Met with Peace Corps, Leprosy Mission (UK), WHO, CMC, USAID Representative, USAID, USAID laboratory technician, IRC

1990

First quarter

- *Meetings with: IOM, screening of IOM Afghan Medical Program (to send patients to Japan and Germany), WHO, MAP, BMMF/TLM (re: monitoring), IMC
- *Brian Duggan as new Hospital Nursing Coordinator
- *Developed new clearance procedures for expatriates

Second quarter

- *New CD, Dr. Joseph Rittman, arrived in April
- *MCI VP of International Programs, Bill Essig, visited
- *Engineer Ayubi resigned (responsible for coordinating MCI/Jamiat)
- *Resolved many issues between Jamiat and MCI
- *Dr. Lloyd Johnson, American thoracic surgeon, visited for 1 month
- *Meetings with delegation of Japanese doctors re: process by which patients would be screened for transport to Japan
- *Judy Michalk, a nurse midwife, visited
- *Cathy Duggan, pediatric nurse, volunteered some time
- *Dr. Ladrillo, dentist, reviewed all dental procedures and curriculum
- *Alice Tanpua, MCI lab trainer, spent 3 weeks in Peshawar observing TB, malaria, and training programs
- *Dr. Jaucian leaves after 3 years with MCI
- *Dr. Elmer Pedregosa left for US
- *Mella Leiter resigned

Third quarter

- *Signed Memorandum of Understanding with Jamiat al-Ulama regarding administrative management of Al-Jehad Hospital
- *Dr. Perry Fisher, an American surgeon, visited to assist with surgical service
- *Janice Jespersion, a Canadian nurse, assisted with MCH
- *Cathy Duggan, nurse, assisted with MCH
- *Judy Michalk, nurse, departed
- *Matthijs Toot helped with information services
- *Mr. Farouq departed, many loyal followers also resigned with him

Fourth quarter

- *Mr. Culver, President of MCI, and Mr. Bill Essig, VP of International Programs, visited Quetta

1991**First quarter**

*Expatriate staff was evacuated mid-January because of the Gulf War

*Dr. Rittman left as country director January 15; John Mitchell appointed Acting Country Director

Second quarter

*Expatriates returned from evacuation

*New Cooperative Agreement submitted to USAID and approved

*Security incidents involving both Pakistan and Afghanistan increased

*John Entwhistle, Nursing Coordinator for Al-Jehad arrived

*Reduced number of expatriates in MCH

*Dr. Ladrillo, dental trainer, departed in June

*Neil Huff, new CD started; Bill Essig and Jerry Dines served as Acting CD during April and May

*\$50,000 stolen in payroll money: security procedures reviewed and improved

Third quarter

*Core group meetings continued

*Mary Barnes, nurse midwife, came to assess female training program for 1 month

*Dr. Pedregosa, Training Advisor, left

Fourth quarter

*Local Hire Medical Advisor, Dr. Marikka Purola-Lofstedt, hired October

*Core Group Meetings continued

*Rene Gensoli, expatriate x-ray supervisor completed his service

*Dr. Kho to continue until March 1992 as OPD supervisor and ward assisting to Dr. Zia

*Francesca Tranter, hired as part-time consultant to assist female nurses at Al-Jehad

1992**First quarter**

*Dr. Shutt of medical project evaluation team visited Quetta in Feb 1992

*Mala Georgian, assistant to Doug Palmer, visited Quetta March 1992

*Jerry Dines visited Quetta

*Regular core group meetings continued

*Dr. Largo Kho finished his contract in February

*Discussions with WHO, AVICEN, Indoors, IAHC, MCI to coordinate EPI in Afghanistan

*Discussions with ANH (Afghanistan Nothilfe) re: Bagh-I-Puhl hospital as MCI training facility

*Michael Enright visited to discuss salary reduction

strategies for inside

*Broad outline of plan to move operations to Kandahar prepared

*Jerry Dines served for 1 month as acting CD

Second quarter

*Cooperative agreement signed for 1992-1993 year

*Core Group meetings continued

*Francesca Tranter completed her service

*John Entwhistle completed his service

*Jelleke van Steenberg hired locally as part-time Nursing Coordinator

*Ritva Jantti hired locally as MCH advisor

*Dr. Lofstedt completed her service July 1

Third quarter

*Neil Huff finished as CD on July 8, new CD, Don Bradford arrived in September

*New Medical Advisor, Dr. Laurie Miller arrived in September for 4 mo

*MCI established an office in Kandahar

*Core Group Meetings continued

*Janice Jespersen finished July

*Dave Kelley, MCI vice president for Finance, visited Quetta in July

*Doug Palmer, Health Devel Officer, USAID, visited Quetta in September to review cooperative agreement

Fourth quarter

*Dr. Imam promoted to Health Division Head

*New Medical and MCH Advisors arrived Greg Hunter and Gail Jenkins

*MCI VP for International Programs, Bill Essig, in Quetta in November

*Doug Palmer in Quetta in December, to Kandahar with Dr. Imam and Don Bradford

1993

First quarter

*Continued planning for move to Mir Wais Hospital

*Doug Palmer, Mella Georgian, and Mella Leiter visited

Second quarter

*USAID notified MCI of plans to withdraw all support for medical programs

*Fourth revision of phase-out plan prepared

*Jerry Dines visited Quetta Apr 5-19

*Tom Hemphill visited Quetta June 3-9

*Carlton Bennett visited Quetta

Third quarter

*Health Advisor, Greg Hunter, resigned

212

*Mella Leiter and Dr. Merrill Shutt visited Quetta

Fourth quarter

*All medical activities concluded

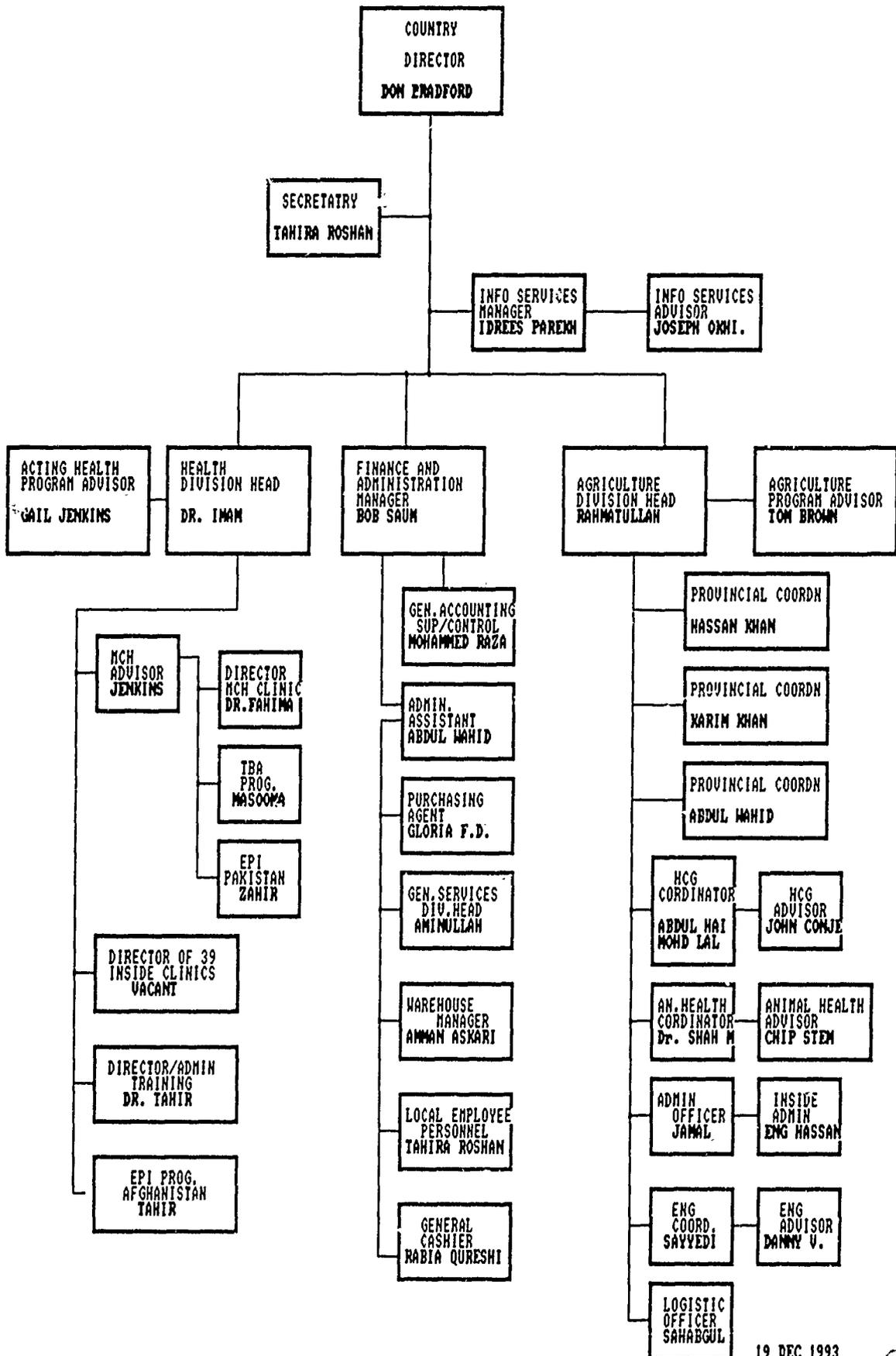
213

ANNEX 15

ORGANIZATIONAL CHARTS

MERCY CORPS INTERNATIONAL

KEY ADMINISTRATION

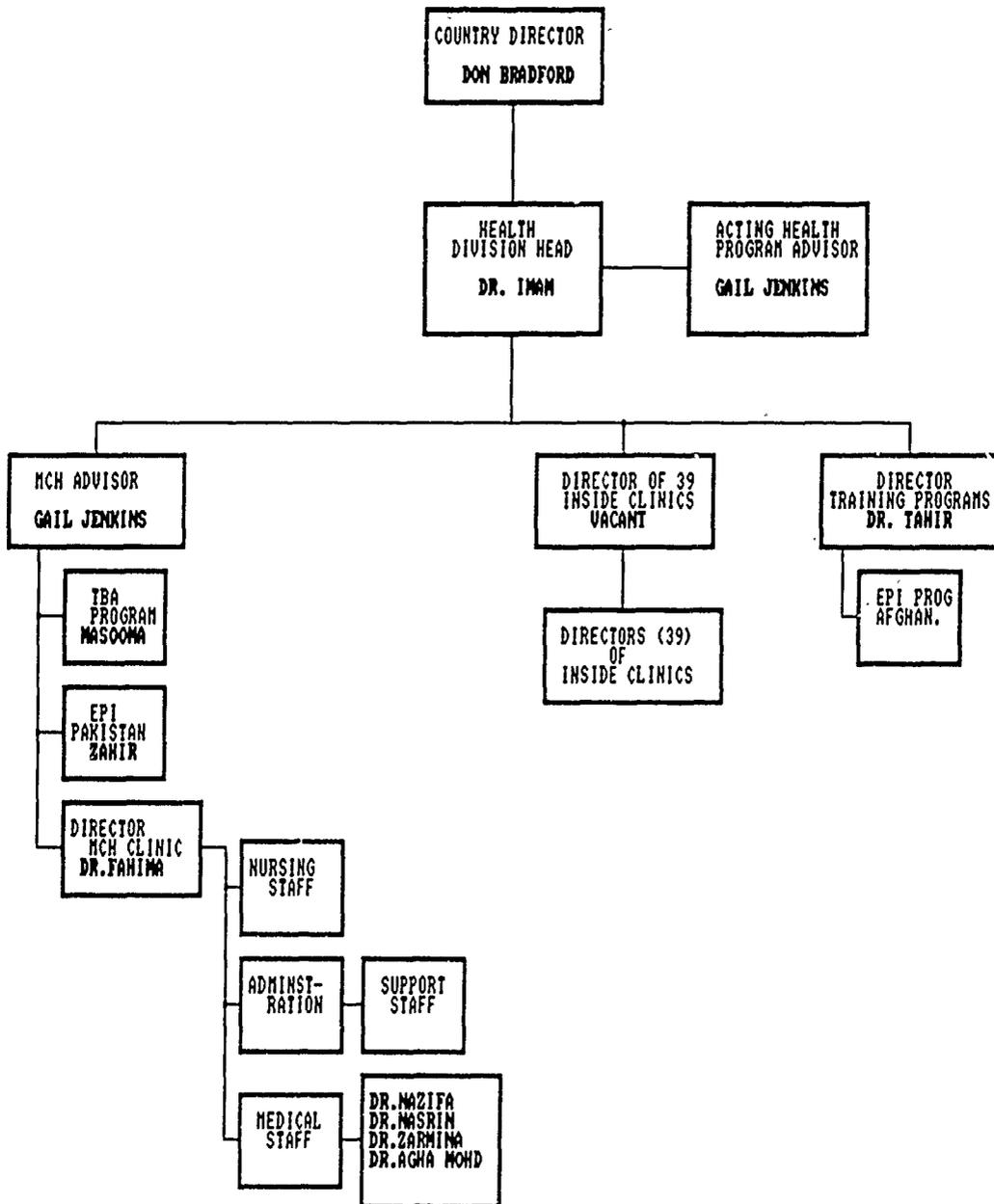


19 DEC 1993

215

MERCY CORPS INTERNATIONAL

MEDICAL DEPARTMENT



19 OCTOBER 1993

ANNEX 16

EXPATRIATE STAFF

ANNEX 16
Expatriate staff

EXPATRIATE STAFF FOR MCI MEDICAL DEPARTMENT

S. No.	NAME	COUNTRY	POSITION	START DATE	END DATE
1.	Jerry Dines	USA	Country Director	01 June 86	31 Mar 90
2.	Joseph Rittman	USA	Country Director	01 Apr 90	31 Jan 91
3.	John Mitchell	New Zealand	Country Director	01 Feb 91	01 Jun 91
4.	Neil Huff	USA	Country Director	01 Jun 91	30 Jun 92
5.	Donald Bradford	New Zealand	Country Director	26 Sep 92	To date
6.	Mella Aalto Leiter	USA	Medical Coordinator	27 Dec 87	31 Jul 90
7.	Dr. Marikka Purola Lofstedt	Finland	Health Advisor	06 Oct 91	30 Jun 92
8.	Dr. Laurie Miller	USA	Health Advisor	01 Sep 92	31 Dec 92
9.	Greg Hunter	USA	Health Advisor	23 Nov 92	15 Jul 93
10.	John Entwistle	New Zealand	Nursing Coordinator	17 May 91	16 May 92
11.	Janice Jespersen	Canada	MCH Advisor (Local Hire, Part Time)	3 rd Qtr. 87	July 92
12.	Gail Jenkins	USA	MCH Advisor	23 Nov 92	31 Dec 93
13.	Rene J. Gensoli	Philippines	X-Ray Technician	10 Nov 90	9 Nov 91
14.	Dr. Largo Vernazo Kho	Philippines	Doctor	10 Nov 90	10 Nov 93
15.	Dr. Elmer Pedregosa	Philippines	Doctor (Midlevel Training)	3 rd Qtr. 88	2 nd Qtr. 90
16.	Dr. Arthur Jaucian	Philippines	Doctor	3 rd Qtr. 87	2 nd Qtr. 90

258

ANNEX 17

CHRONOLOGY OF USAID-FUNDED MCH ACTIVITIES 1986-1993

ANNEX 17CHRONOLOGY OF USAID-FUNDED MCH ACTIVITIES 1986-1993**INTRODUCTION**

During the time period of this project, the United States Congress mandated that maternal and child health activities must be a component of all foreign assistance given for medical programs. Thus, donated aid should directly benefit women and children. The traditional cultural practices in Afghanistan made fulfillment of this mandate difficult. Nonetheless, as demonstrated by the chronology below, considerable effort was exerted by MCI to fulfill this goal. These accomplishments must be viewed in the cultural context in which they were achieved, that is, a tradition in which women live in complete seclusion in their homes and compounds. It should be noted that with the assistance of other donors, MCI established an extremely effective TBA training program in the refugee camps around Quetta, with 12 trainers working and over 1000 women trained each year. In addition to the extremely active USAID-funded EPI program operated by MCI at the Quetta MCH clinic, MCI also operated non-USAID funded EPI programs at 9 sites inside Afghanistan.

1987

- *Started a health education program for women at Al-Jehad
- *Developed plans for a TBA program using training material from UNICEF
- *Began search for site for midwife practical training

1988

- *Established MCH room at Al-Jehad OPD
- *Identified 2 female staff to work in TBA program; sent to Bannu for practical experience
- *Selected 14 women in Kandahar for TBA training, but only 2 arrived in Quetta and after further screening, both were found to be unsuitable candidates
- *Postponed course because of lack of qualified, experienced trainer
- *Again requested commanders in Kandahar province to send women for TBA training; none sent
- *Expanded MCH prenatal and postnatal facilities to use for TBA practical training, but continued difficulty locating a suitable instructor
- *Developed a curriculum and facility to train for female health workers, but all efforts to persuade commanders and other leaders in Kandahar to send women for the course were fruitless
- *Afghan nurse working at MCH clinic resigned; reduced MCH activities to 3 days each week

1989

- *Included female patients in OPD; students thus encountered women in this setting for the first time
- *Hired another Afghan nurse to supervise MCH clinic

1990

- *Hired an experienced Afghan midwife for the MCH department
- *MCH services included infant feeding program, growth monitoring, and immunizations
- *Moved MCH services to separate facility
- *Opened 5-bed female surgical ward

1991

- *Expansion of MCH staff
- *All MCH workers trained in water sanitation and parasite prevention
- *Finalized 3 month MCH-assistant course, started training late June
- *10 students accepted for course, but only 6 were permitted to attend
- *Mid-level students began rotations through MCH clinic: thus exposed to child health problems for the first time
- *Inservices for MCH staff on infant examination, hygiene, ORT, nutritional education, mine awareness
- *Started ORT and nutrition corners
- *Completed 3 month MCH-assistant course, 5 students graduated; none could be placed in clinics Afghanistan which had been prepared due to USAID suspension
- *Dr. Fahima, Afghan physician, appointed head of MCH clinic
- *Added staff nursery to MCH clinic to encourage breast-feeding and early return to work after delivery by staff
- *Completed MCH manual in English
- *Fee-for-service and for non-essential labwork initiated at MCH clinic

1992

- *Fees for medicine at MCH clinic initiated
- *4 MCH trainers attended TOT workshop
- *Second MCH-assistant course delayed because of floods; finally started May
- *MCH manual Pushto and Dari translations completed
- *Placed trained MCH-assistant in Khakraiz clinic in March
- *Relocated MCH clinic to new separate site
- *Selected students, began training of female mid-level students (MCH-officers), but required by USAID to suspend this course pending standardization
- *Participated in meetings to establish standardized MCH-officer course
- *Began second MCH-assistants course

*3 trained MCH-assistants assigned to Malestan but unable to assume posts due to security constraints; 3 others await placement because of poor security situation

*Included female doctors on morning rounds of hospitalized patients for first time

*Notably, review of monitoring reports revealed that ~50% of patients cared for at MCI's clinics in Afghanistan were women and children

ANNEX 18

DOCUMENTS PRODUCED

22³

ANNEX 18DOCUMENTS PRODUCED

A Practical Guide to Common Illnesses in Afghanistan: a therapeutic field manual (169 pages, illustrated). Produced in association with the Coordination of Medical Committees, Peshawar, 1989.

Monitoring and Evaluation Missions of Health Workers and Clinics in Rural Afghanistan: May to November 1991 (104 pages, photographs, plus annexes). Produced in association with the Coordination of Medical Committees, Peshawar, 1991.

MANUALS FOR AFGHAN HEALTH WORKERS:

First aid

Nursing skills

X-ray skills

Dental skills

Laboratory skills

Common diseases for mid-level health workers (and formulary)

Translation of WHERE THERE IS NO DENTIST by MCI for Health Education Resource Center in Peshawar 4th quarter 1988

Memorandum of Understanding between Jamiat al-Ulama and MCI 1990

Afghan Refugee Children and Mothers. Archives of Pediatric and Adolescent Medicine, in press, 1994. (Miller LC, Timouri M, Wijniker J, Schaller JG).

ANNEX 19

SUMMARY OF MAJOR POLITICAL EVENTS

DURING THE TERM OF PROJECT

112

ANNEX 19Summary of major political events during the term of the project

- 1979 Invasion of Afghanistan by (former) Soviet Union
- 1986 Resistance to Soviet Union invasion continues
- 1988 Departure of Soviet Union troops
- 1988 Intensification of combat in Kandahar province
- 1991 U.S. involvement in Gulf War: evacuation of all expatriate staff from Quetta for ~3 mo
- 1991 Political unrest in Pakistan: curfew for 11 days
- 1991 USAID mandated suspension of all medical activities in Afghanistan (~4 mo)
- 1992 Downfall of Najibullah government in Kabul, takeover by mujahadeen
- 1992 Political unrest in Pakistan: curfew for 5 days
- 1993 Intense civil conflict in Kandahar recurs: destruction of Mirwais Hospital and forced evacuation of training staff

26

ANNEX 20

CRITICAL APPRAISAL OF THE PROJECT

221

ANNEX 20Critical Appraisal of the Project

A project of this magnitude and duration is difficult to sum up in a few short paragraphs. However, viewed retrospectively, some points definitely stand out. The successes of the project are especially remarkable in view of the significant turnover in long-term expatriate management personnel. MCI's Quetta operations had four different Country Directors and several Acting Country Directors within a span of 20 months. Similarly, the position of Medical Advisor went unfilled for many months at a time. During the time of the project, there were multiple periods of curfew in Quetta, as well as a 4 month period during which all expatriate staff were evacuated (the Gulf War). During these periods, MCI was extremely fortunate in the caliber and loyalty of its Afghan staff. Many of these individuals worked for MCI throughout the project period. They assumed significant managerial responsibility, and deserve credit for providing substantial program continuity.

A major difficulty in appraising the project was the failure to incorporate any specific outcome measures into the project plan. While the purpose of the Medical Help Project for Southwest Afghanistan was to improve the general health of the population, no mechanism was incorporated into the project to assess this variable. It would have been desirable to establish the health and survival statistics of the population in the target area prior to the intervention of introducing trained health workers. Followup surveys to establish efficacy and to target areas of improvement would then have been possible. However, given the civil disruption and war, and the resulting transience of the population, such an endeavor would have been neither practical nor accurate. However, a small-scale impact assessment perhaps could and should have been attempted.

The changes in directives received from the donor were also problematic at times. For example, the mandated changes in method of supply were difficult to incorporate into a well-established, smoothly running system which had been developed to prevent waste, to ensure provision of needed items, and to offer timely and secure delivery. The directive to close redundant clinics serves as an additional example: while the necessity to reduce costs is appreciated, perhaps "no redundancy" could have been included as a criterion at the time of the initial establishment of clinical facilities. More important, while short-term goals were clearly stated, planning for longterm goals was suboptimal, due in part to the fact that these longterm goals were implicit rather than explicit. Even when clearly stated, the time frame for implementation of the longterm goals was not always evident. For example, while "sustainability" was recognized as a desirable aim, adequate planning to ensure this

623

was not incorporated into the project plan from the beginning. Earlier clarification that donor support was of limited duration would also have been helpful in community relations. Nonetheless, it is gratifying that some former clinics are still functioning as long as one year after withdrawal of support.

Changing availability of financial resources from the donor was also problematic. At times, "windfalls" of money were made available to MCI, with minimal advance budgetary planning. Although these funds were put to good use, more substantive planning would have been beneficial.

Many of these problems directly relate to the unstable and changing situation in Afghanistan, something over which neither MCI nor the donor had control.

The accomplishments of MCI's programs are especially notable given the political instability and the serious security concerns in the region. High-quality training programs were conducted, with more than 600 health workers receiving academic and practical instruction. Because of MCI's system of selecting students, attrition rates were extremely low, with an unusually high percentage of students returning to Afghanistan to work. Undoubtedly, establishment of health facilities staffed by these trained health workers have had a positive impact on the health and well-being of the general population in SW Afghanistan.

Throughout this project period, MCI developed and sustained an outstanding reputation for its programs and for its fairness and political neutrality. The significance of these accomplishments cannot be underestimated; this reputation was the basis which made all of MCI's activities possible.

In conclusion, the partnership of USAID and MCI in the implementation of the Medical Help Project for SW Afghanistan resulted in a remarkably successful project. Given the climate of political instability and active hostilities, these accomplishments are especially noteworthy. Although problems were encountered at many levels, these were usually successfully resolved. The project provided significant contributions to emergency medical assistance and to improvements in health care delivery to SW Afghanistan. With the conclusion of the project, both partners can review their achievements with pride.

ANNEX 21

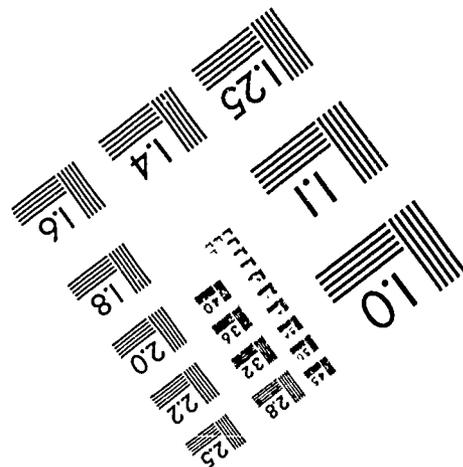
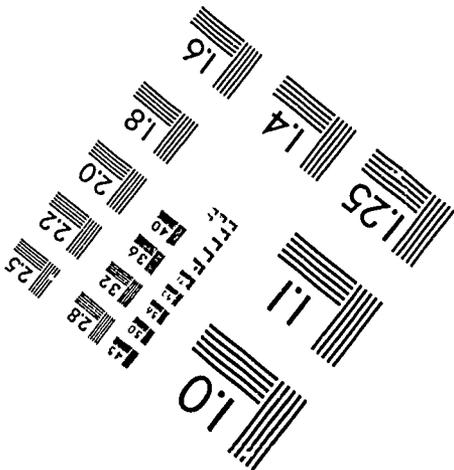
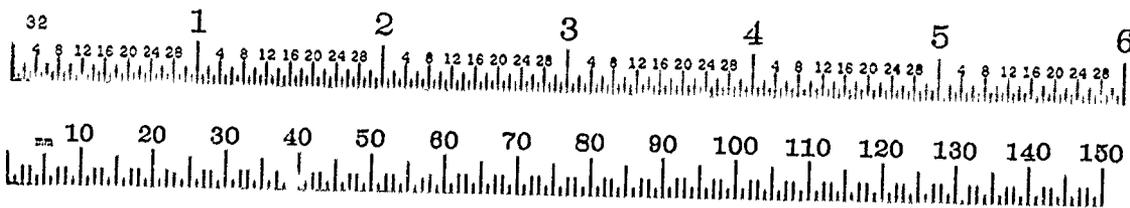
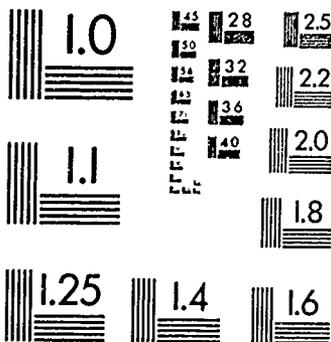
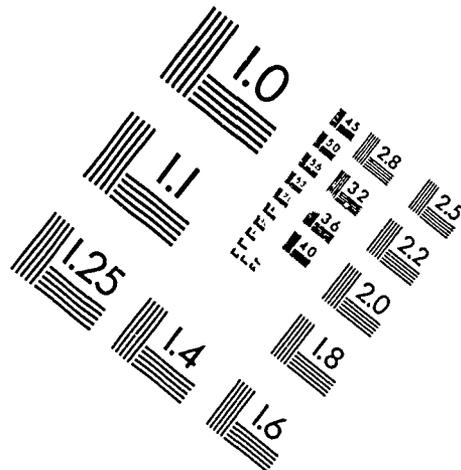
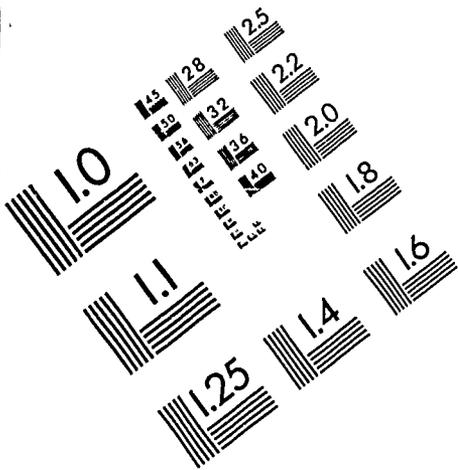
LIST OF ABBREVIATIONS

ANNEX 21LIST OF ABBREVIATIONS

ACBAR	Agency Coordinating Body for Afghan Relief
AHSA	Area Health Service Administration
AICF	Aide Internationale Contre la Faim
AMA	Advanced Medical Assistant (mid-level health worker)
AMI	Aide Medicale Internationale
ANH	Afghanistan Nothilfe Association for Coordination
AVICEN	Afghanistan Vaccination & Immunization Center
BBC	British Broadcasting Corporation
BHW	Basic Health Worker
CD	Country Director
CDD	Control of Diarrheal Diseases
CKS	Combined Kit System
CMC	Coordination of Medical Committees
CMCEP	Combined Mid-level Continuing Education Program
CPS	Combined Procurement System
DOD	Department of Defense
EPI	Expanded Program of Immunization
IAHC	Islamic Aid Health Center
ICM	Intergovernmental Committee for Migration
ICRC	International Committee of the Red Cross
IMC	International Medical Corps
IOM	International Organization for Migration
LEPCO	Leprosy Control Organization
MAP	Medical Assistant Program
MCH	Maternal Child Health
MCH-A	Maternal Child Health Assistant
MCI	Mercy Corps International
MIS	Management Information System
MSH	Management Sciences for Health
NGO	Non-Governmental Organization
O/AID/REP	Office of AID Representative
OHI	Organization of Handicap International
OPD	Out Patient Department Organization
ORS	Oral Rehydration Solution
ORT	Oral Rehydration Therapy
ORW	Out Reach Worker
OT	Operating Theater
PHC	Primary Health Care
PT	Physical therapy
RN	Registered nurse
SA	Swedish Committee for Afghanistan
SCF	Save the Children Foundation
SW	Southwest
SWABAC	Southern & Western Afghanistan, Baluchistan
TB	Tuberculosis
TBA	Traditional Birth Attendant
TOT	Training Of Trainers
TPHW	Transitional Public Health Worker

UN	United Nations
UNDP	United Nations Development Program
UNESCO	United Nations Education Scientific and Cultural
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations International Children's Emergency Fund
UNILOG	United Nations Logistics Operation
UNOC(H)A	United Nations Organization for Coordination of (Humanitarian) Assistance
USAID	United States Agency for International Development
VP	Vice-President
WFP	World Food Program

IMAGE EVALUATION TEST TARGET (MT-3)



APPLIED IMAGE
1653 E. MAIN STREET
ROCHESTER, NY 14609
TEL (716) 482-0300
FAX (716) 288-5989

90

50