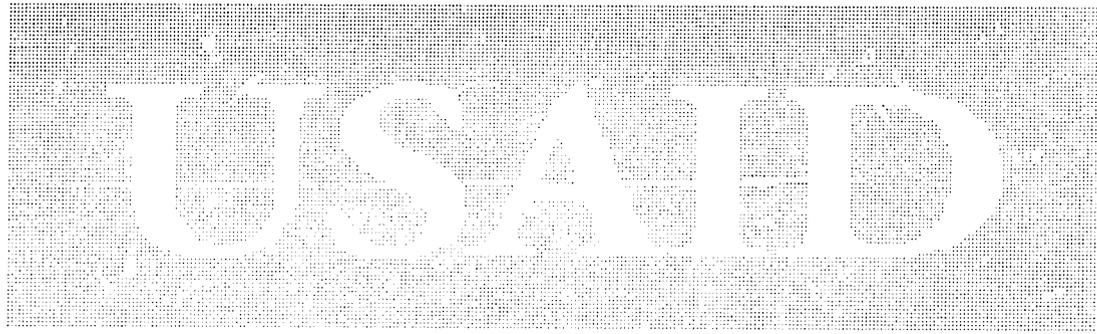
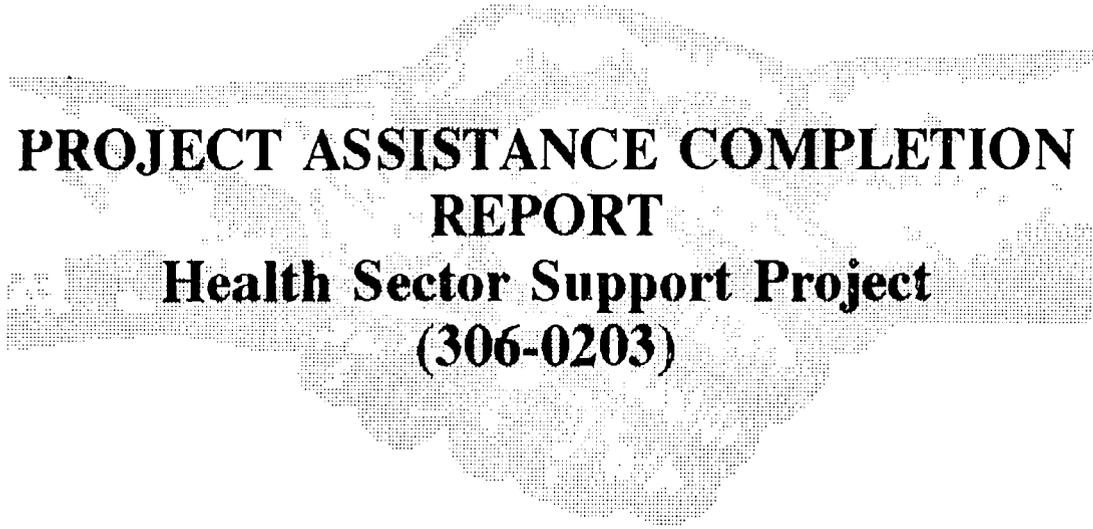


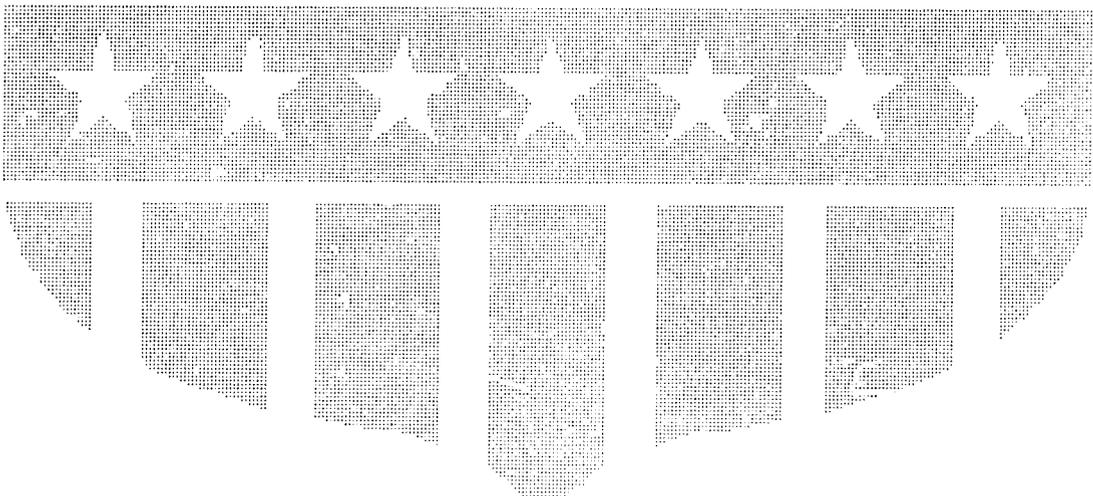
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**MISSION TO PAKISTAN AND AFGHANISTAN**



**PROJECT ASSISTANCE COMPLETION  
REPORT  
Health Sector Support Project  
(306-0203)**



*Submitted by Office of Afghan Field Operations  
May 1994*

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## LIST OF ACRONYMS

AAM	Activity Approval Memorandum
AHC	Alliance Health Committee
BHW	Basic Health Worker
CMC	Coordination of Medical Committees
CMCEP	Combined Mid-level Continuing Education Program
EPI	Expanded Program of Immunization
HCCA	Health Committee of Central Afghanistan
HHS	Household Surveys
HSSP	Health Sector Support Project
IPH	Institute of Public Health
LOP	Life of Project
MCH	Maternal and Child Health
MCHO	Maternal and Child Health Officer
MOPH	Ministry of Public Health
MSH	Management Sciences for Health
NGO	Non-government Organization
PHC	Primary Health Care
PPHO	Provincial Public Health Officer
RHA	Regional Health Administration
RHO	Regional Health Officer
SCNA	Supervisory Council of the Northern Area
TT	Tetanus toxoid
VHS	Volunteer Health Sister
WHO	World Health Organization

# PROJECT ASSISTANCE COMPLETION REPORT

## HEALTH SECTOR SUPPORT PROJECT (HSSP) - (306-0203)

May, 1994

### 1. BASIC PROJECT DATA

PROJECT NAME:	Health Sector Support Project		
PROJECT NUMBER:	306-0203		
PROJECT OFFICER:	Doug Palmer		
ASST. PROJECT OFFICER:	Mella Leiter		
TECHNICAL ASSISTANCE CONTRACTOR:	Management Sciences for Health		
Action	Dates	PACDs	AUTH. AMOUNTS
Authorization	8/8/86	09/30/89	\$16.6 million
Amendment No. 1	9/30/88	12/31/92	\$60.6 million
Amendment No. 2	07/17/92	06/30/93	\$60.6 million
Amendment No. 3*	07/30/92	06/30/94	\$65.0 million
Total Obligations:	\$57,011,000		
Total Expenditures:	\$50,517,151 (as of 03/31/94)		
Deobligation of \$4.4 million was accomplished in 1994 to meet the Afghanistan program rescission target.			

### 2. PROJECT GOAL AND PURPOSE

Goal: The original goal, as given in the 1986 Activity Approval Memorandum (AAM) - the AID/Rep/Afghanistan equivalent of the Project Paper -- and as slightly amended following the 1988 assessment, was to:

Improve the health status of the people of rural Afghanistan (through):

a. improving first aid and emergency services including medical and surgical care for war casualties -- phasing down as the need subsides;

b. expanding general primary and secondary health care services for civilians, including women and children as well as the Mujahhidin (the guerrillas whom the U.S. Government supported against the Soviet-supported Afghan communist government based in Kabul); and,

c. enhancing the capabilities of the Alliance Health Committee (AHC) (representatives from the major guerrilla military/political parties) or other organized Afghan entities or organized areas (private or public) -- to plan, organize and manage expanded health care activities.

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The above amended objectives differed from the original purpose in that there was a deemphasis on providing "medical and surgical care for war casualties," and in the inclusion of health care services to civilians, "including women and children."

The AAM was amended in 1992. This amendment, basically driven by the fall of the communist government in Afghanistan and the expected transition of the program to a Kabul base, incorporated refined project objectives to:

- a. support the basic health care delivery system;
- b. promote maternal and child health care (MCH) and immunization programs;
- c. upgrade skills of those involved in delivery of health care services; and
- d. strengthen Afghan organizational capability to deliver health care.

These revised objectives were essentially a result of project implementation experience and two very good project evaluations conducted in 1990 and 1992.

### 3. PROJECT COMPONENTS

The project was divided by MSH -- and USAID -- into six, rather artificial, components: Training, Health Services Implementation, Maternal and Child Health, Child Survival and Disease Control, Procurement and Supplies Management Services, and Finance. MSH -- which was the sole implementor of the HSSP -- had expatriate advisors heading each of these components (departments) and it used these components in its quarterly reports and the Final Report. (MSH's Final Report and USAID's final Project Implementation Reviews, dated 3/31/94, should be read in conjunction with this PACR.) Each of these project components is discussed below in detail.

#### *Training*

The HSSP, through MSH, supported the training of medical, health and support personnel at all levels of the "health pyramid" -- with "basic health workers" (BHW), trained for three months, at the base of the pyramid, up to Afghan medical doctors sent to the U.S. as short term participant trainees at the top. MSH also provided a two-day, First Aid training course to mujahhidin fighting the communists.

The health NGOs funded by USAID did their own training; however, MSH supported all its training through its Afghan counterparts. These included the Alliance Health Committee (AHC) -- composed of the major mujahhidin political/military parties -- which evolved into the Ministry of Public Health (MOPH), and the Regional Health Administrations (RHAs), of which there were four: the North, the South-southwest, the Hazarajat (in central, Shia Afghanistan), and, in eastern Afghanistan, Paktya and Paktika. Most training, however, was done under the auspices of the Institute of Public Health of the MOPH.

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In the initial years of the project, all training was done in the border areas in Pakistan, none in Afghanistan. Following the withdrawal of the Soviet troops in 1989, USAID directed MSH to encourage training be held inside Afghanistan. With the fall of the Kabul-based communist government in 1992, USAID withdrew its support of training in Pakistan to require all training to be held in Afghanistan. At about this time, USAID also mandated that no new male health/medical workers be trained, as the number of health workers supported greatly exceeded sustainable levels. All training for males after early 1992 was for continuing education, "refresher courses" to upgrade skills of existing health providers, or for female health workers. Through the HSSP, USAID provided continuing education courses to the Afghan counterparts of MSH and to health workers supported by NGOs, such as the Swedish Committee, International Medical Corps, and Mercy Corps International.

### *Health Services Development*

During the project, MSH, with its Afghan counterparts, pieced together the outlines of a rational, hopefully a broadly sustainable, medical/health delivery system for Afghanistan.

Development of health services only began after the HSSP had rapidly produced hundreds of basic health workers, to meet what was seen as the needs of the war situation. It was not until after the 1988 evaluation cum AAM amendment that the Project began focusing on the development of a delivery system for rural, resistance-held Afghanistan, where 80% of the population lives.

The system developed by the Afghan officials, with plenty of coaching from MSH -- and with key short-term participant training in the U.S. (Boston University) -- was one focusing on primary health care (PHC), with a village-based emphasis.

MSH developed and extensively used a "computer assisted" PHC training model, call SUSPLAN -- "sustainable planning". MSH taught the MOPH and RHA planners how to use SUSPLAN; numerous workshops were held, ending in the development of health delivery plans for each region of the country. The MOPH, under the auspices of WHO -- with assistance from MSH -- also played a large part in developing a five-year Health Plan for the entire country.

### *Health Services Implementation*

Health Services Implementation, run out of the "Field Operations" Department of MSH, was responsible for working with the MOPH and the RHAs for the siting of health facilities, assignments of personnel, determination of supply needs, and monitoring. In theory, this department carried out plans agreed upon by the health development planners.

Field Operations, and its counterparts, had both computer assisted, and hand-tabulated systems to keep track of the thousands of personnel, hundreds of facilities, and the tons of medicines and equipment needed to run the system. (The hand-tabulated system was kept for

the eventual transfer of the operations to Kabul, where computer systems would possibly not be sustainable.)

Field Operations also was responsible for "Provincial Health Resources Surveys." These were used to identify areas of the country which needed health facilities/workers, and which did not.

### *Maternal and Child Health (MCH)*

MCH became a separate department in 1989, because of the 1988 evaluation; and implementation experience pointed out that those most in need of health care were women and children. (War wounded accounted for less than 3% of the patients seen by BHWs or at fixed health facilities at any time during project implementation. See attachment No.1). MCH concepts, such as pre- and post-natal care, oral rehydration therapy and even family planning were introduced into the training curricula of the various levels of male health workers. (An Expanded Program of Immunization [EPI], which is one of the major MCH interventions, was introduced separately, and was included in a different project department. See below.) The most notable endeavor within this component was the attempt to deliver MCH services via female health providers within the very conservative Afghan cultural milieu. Women trained to provide services at the village level included dais, traditional birth attendants (this is a standard practice in many third-world countries) and Volunteer Health Sisters (VHS), a new category of female health workers based on the Urban Health volunteer system developed in Bangladesh under USAID support. MCH health posts and clinics were established -either separately or in conjunction with "general" health facilities. These were for the most part staffed by women.

### *Child Survival and Disease Control*

This component included the extensive EPI program funded through the HSSP. Close to 190 immunization teams, deployed throughout the country and managed by the MOPH and RHAs, were supported by MSH through this component, which was headed by an expatriate physician. USAID, basically through the HSSP, provided approximately 40% of all the immunizations given in Afghanistan.

The six major antigens were given: polio, DPT, measles and tetanus toxoid (TT). WHO standards were followed, e.g. children under two years of age were emphasized, and MSH worked closely with UNICEF. Indeed, all vaccines were provided through UNICEF and UNICEF standardized "cold chain" equipment was used. MSH, through its Afghan counterparts, normally used a fixed facility/out-reach -- rather than a mobile -- system of providing immunizations to children and girls/women. Providing TT to pre-pubescent females was often practiced, given the conservative custom followed in many areas of the country of female exclusion or "purdah".

The Child Survival department was also directly responsible for training EPI personnel, vaccinators and cold chain technicians; this was handled separately from other training programs managed by MSH Training section.

The Child Survival and Disease Control department also covered tuberculosis treatment and control of diarrheal diseases. In addition, mapping and household surveys (HHS) were conducted.

### *Procurement and Supplies Management Services*

This component encompassed the procurement, warehousing and issuing of medicines, medical equipment and supplies for the operations of MSH and its supported training programs, the running of the sustained MOPH and RHA administrative centers and, importantly, the implementation of over 1,300 one-man health posts (on average) and approximately 500 clinics and small hospitals throughout Afghanistan. For the most part, procurement was accomplished by the Mission's central procurement agent, (initially AMEG, then RONCO). MSH, however, was responsible for quality control and the organization and distribution of medicines and supplies received in bulk form from the procurement agent or, usually, directly from the commercial supplier.

MSH Procurement developed a computerized software system to keep on top of inventory and projected needs. This was a boon, as hundreds of tons of medicines and equipment were purchased and sent into Afghanistan during the life of project. Over 40% of the entire program budget went to procurement, warehousing, assembly and distribution of supplies.

The Procurement department was also responsible for quality control of medicines purchased. Only MSH had a system to attempt to verify the quality of the medicines and medical supplies in a region where spurious medicines are a serious problem. None of the NGOs funded by USAID to run health activities had any system to assume that medicines or medical supplies were good. (This led to a "common kit"/procurement system, run by MSH, which is discussed below.)

### *Finance*

MSH's Finance Department was basically responsible for disbursing and accounting of all program funds. Fund disbursement from Peshawar for program support was made in both Pakistani rupees and Afghanis: rupees were paid out for local purchases and for salaries of personnel on both sides of the border. The Afghani to rupee exchange rate was too precarious to be acceptable to personnel -- the Afghani to dollar rate increased from 198 in 1987 to 2,100 in 1994 while the rupee remained relatively much more stable. (Personnel, particularly with access to Kabul, could also achieve a profit on the exchange rate from rupees to Afghanis.) The commercial transportation of goods to various parts of Afghanistan, however, was always paid in Afghanis.

The Finance Department also trained Afghan accountants working with the MOPH and the RHAs, to attempt to create self-sufficient financial departments within these entities. Finance worked closely with the monitoring unit -- under Field Operations -- to verify if salaries, per diem and other cost should be paid, based on monitoring reports.

#### 4. INPUTS

All project funds were obligated to the Cooperative Agreement with Management Sciences for Health. The total amount of funds expended through the LOP will be approximately \$52,000,000: approximately \$40 million for Program; \$10 million for Technical Assistance; and \$2 million for Logistical Support. (Logistical Support covers housing and office rent, etc, which is paid directly by USAID and charged to the MSH cooperative agreement). Of the approximately \$40 million spent for Program costs, 40% was for medicines, medical supplies and freight to get these commodities to the health facilities; over 36% was expended for salaries of the Afghan health workers and to the people who supported them. (See attachments 1-5 for project expenditures.)

UNICEF provided vaccines for the HSSP immunization program. The estimated value of this input -- which includes transportation from Europe -- through the LOP -- is \$1,100,000.

There was no counterpart, formal government. This was a unilateral project, thus no contributions in this project came from the Government of Afghanistan. A significant amount of MOPH and RHA personnel time, however, was provided "in-kind" -- we approximate the value at up to \$500,000 during the LOP. The funds to support these people came from "Arab" donors -- governmental and private-- and from another U.S. Government agency. There were no other significant donors to the project.

#### 5. PROJECT ACCOMPLISHMENTS

##### *Training*

MSH worked with the Afghan Alliance Health Committee, later to become the MOPH, to develop an exceedingly competent, very professional training department within the Ministry of Public Health. The Institute of Public Health (IPH) was and continues to be headed by Dr. Sayed Mohammad Amin Fatimie, who is presently the acting Minister of Health for Afghanistan. Dr. Fatimie and many of his staff were project participants sent to the U.S. for short term training in public health concepts. The project participant training, although not extensive (22 participants) has paid many dividends. It was money well spent, as these people became the core of the IPH and, to a much lesser extent, conducted the training efforts at the Regional Health Administration training sites.

MSH worked with the MOPH/IPH and the RHAs to develop a number of training programs for different categories of medical/health workers. They also, through the LOP,

worked collaboratively to set up training sites around Peshawar in Pakistan, at Miram Shah in North Waziristan, and inside Afghanistan in Takhar, Wardak, Balkh, Herat and Kandahar provinces.

MSH supported the Afghan entities to train a variety of medical/health workers. Below, we take a brief look at each type of worker/training effort and assess accomplishments. (Note: the Training department contains some of the accomplishments which could also fit under Health Services Development or Field Operations since there is, of course, overlap between these areas. This, in part, accounts, for the length of the following assessment of the Training activities conducted under the HSSP.)

1. *First Aid ("Buddy Care")*: Over 37,000 mujahhidin were provided two-day training in basic trauma care. This was done for military reasons. The training appeared to be adequate. No assessment was done. MSH continued to provide this training until July, 1991. It should have ceased several years earlier, as it detracted from efforts that could have gone into more productive categories of health worker.

2. *BHWs*: MSH did a commendable job of quickly putting together a basic medical-oriented training program for what was termed "basic health workers" (or BHWs). MSH worked with the Afghan Alliance Health Committee (later to become the MOPH) to develop its Training Department (to become the Institute of Public Health). Early on, a decision was to go with a village (or military unit) level health worker. Most BHWs worked out of their homes, or from a community-provided building. These were called "health posts". Some were always mobile. BHWs (all were males) were trained for approximately three months; and refresher training was given when they were resupplied, on average, once a year. BHW training, through the LOP, increasingly included primary health care skills, such as oral rehydration. BHWs saw a significant number of women and children. In total 2,255 BHWs were trained. The drop out rate was high (the salary was low, and, as many were farmers, they were expected to be part-time workers in any case), thus at the end of the project there was less than 1,000 BHWs on the rolls.

Basic Health Workers were a good choice to begin with, and on which to rapidly build a health system for war-torn Afghanistan. To our knowledge, BHWs will not be supported by any donor or governmental entity after the HSSP is ended. It is believed, however, that many of the trained BHWs, at least those that are perceived by the community to provide a useful service, will continue service to their communities on a part-time basis, being supported on a fee-for or "chicken-for" service method. Reports from various sources have indicated that many BHWs had previously gone into private practice.

3. *Rural Health Officer (RHO)*: The RHOs were seen as technical supervisors of the BHWs and of the lower-level health workers of the medical/health workers based at clinics and small hospitals. Superior BHWs were selected to be trained in an 11-month (reduced to a 6-month) course. The RHO was to be placed in clinics and supervise the BHWs in his "region." He was to be supervised by a Provincial Public Health Officer (PPHO). The training course was well put together, although not standardized with WHO. This concept of worker, however, is

one that WHO recommends and MSH and its Afghan counterparts were wise to institute this level of supervisor within the developing health system. MSH reports that at the end of the project -- to its knowledge -- most of the 20 RHOs trained were continuing at their work assignments and they all were assigned to their home areas. We believe that the Afghan governmental entities will not be able to continue the RHOs in the future.

**4. Provincial Public Health Officers (PPHOs):** These health system supervisors were originally a concept developed and implemented prior to the Soviet invasion in 1979. The idea is to have a senior medical person, normally a physician, who has received supervisory training and also has a thorough grounding in public health skills. The desire for instituting PPHO training resided with the MOPH. The Ministry selected five individuals within the last two years of the project. They were trained and assigned, but never were accepted since they represented the MOPH, whose authority did not extend to the provinces.

**5. Maternal and Child Health Officer:** The first MCHO course was taught in Peshawar with 10 female graduates from the 12-month course. The curricula for the course was good; however, the majority of the students were recruited from Pakistan-based refugee camps and, upon graduation, the MCHOs were unable (culturally) or unwilling to go and work inside Afghanistan. Three of the 10 were recruited from Afghanistan and all three returned and took up their posts and remained there.

For the second course, USAID required that the MCHO training be held inside Afghanistan. Recruitment was more difficult and took a long time. Results showed that the selected candidates were apparently not chosen with specific criteria in mind (areas of need, nor verified community support, etc.) but rather that all 13 candidates selected for the second course, held in Jalalabad, were selected because they were Pashtun, with other ethnic groups (Tajiks, Hazaras, etc.) not selected based on the assumption (or biases of the MOPH) that they would have problems living and training in Pashtun Jalalabad, Nangahar Province. In total, 20 women graduated from the MCHO course during the LOP. This is a respectable number given the fact that MCH started late in the project, and because of the cultural sensitivities towards training females.

**6. Volunteer Health Sisters:** The VHS was the idea of MSH. It evolved from the documented need to reach the women and children at the village household level. The only way to do this, in the conservative Afghan milieu, is to have women going door-to-door, delivering basic health messages and care, and referring those in need to nearby health posts or clinics. Ideally, VHSs should be trained at MCH clinics, where female health care providers were stationed. However, of the 164 VHSs trained the majority were trained at "non-MCH" clinics where there were no females, and one questions the quality -- or at least the thoroughness -- of the training, as well as the ability of male health workers being able to supervise VHSs in the field/household setting.

**7. Dais (Traditional Birth Attendants):** MSH reported that 457 dais were trained during the LOP. Dais were mostly trained by BHWs, although the initial training of the traditional

birth attendants -- which has been done in many other third-world countries to mixed reviews - - was supposed to be done at the MCH clinic or post. Dai training was planned to be an integral part of the MCH program, with all MCH center staff having the ability to train dais. Unfortunately very few of the MCH centers established actually performed this service. MSH reports that on average BHWs trained four dais each, during the last 12 months of the project.

8. *Field Microscopist Training:* As clinical services expanded, there was a need for microscopists. MSH, as well as others, developed a training course to produce basic laboratory technicians and/or field microscopists to staff the comprehensive care clinics and small hospitals. The training was for 20 weeks. Only 18 field microscopists were trained, all in Peshawar. Although MSH claims that the course was standardized to WHO criteria, it was not, which makes certification difficult. (Non-WHO standardized courses developed by disparate NGOs and other implementing entities were a significant problem in Afghanistan.)

9. *Refresher Courses and Medical Certification:* MSH developed refresher (continuing education) courses for doctors, nurses and other "mid-level" health workers and BHWs. Normally, refresher courses were given when individuals returned for resupply, usually to Peshawar. A total of 170 doctors and nurses, and 3,457 BHWs received refresher courses during the LOP.

Medical Certification testing was developed in conjunction with the MOPH. This was essential because of the incredible variety of training programs, making it impossible to determine the competence of the worker to be considered for support by either the title or the degree, or the duration of training. A Medical Certification Board was formed at the MOPH/Peshawar to establish a uniform medical certification process and to evaluate the skills and knowledge of health professionals considered for support under the HSSP. Unfortunately the efforts of this Board were not coordinated or standardized with those of WHO or any other health agencies in the community who were involved with standardization of skills and knowledge of health workers.

10. *Combined Mid-level Continuing Education Program (CMCEP):* Because of the lack of standardization of many of the training courses, as pointed out above, USAID, along with WHO and other donors (notably the EC), insisted that the groups they funded standardize training and certification. USAID viewed the mid-level health worker (6 to 18 months training) as the key to health delivery in Afghanistan, both at the time of project implementation and in the foreseeable future. Thus standardization was initially targeted at this level. All major donors and implementing entities participated in the development and the running of the CMCEP whose aim was to standardize the disparate training/skill levels of mid-level health workers practicing in Afghanistan. This training course, the curricula of which is in both Dari and Pashtu, is one of the outstanding accomplishments of the HSSP and of other USAID assistance in health for Afghanistan. Sadly it came about only in the last two years of the project, only approximately 175 midlevel workers went through the 18-week course (34 supported by MSH) by March, 1994.

*11. Management Training:* MSH conducted several, very well run management workshops for RHA and MOPH administrators and planners. A Basic Administrative Workshop was held in 1990; during the same year and again in 1991, Senior Manager Workshops were conducted. A "Master Management" training course was developed and implemented. Management training was extremely important and paid big dividends by leaving behind a small but significant cadre of health planners and managers with which other donors can work.

### *Health Services Development*

As reported by MSH, one of the major outputs within Health Services Development was the design of a computer-assisted health planning model call SUSPLAN. This model essentially took all the standard variables (e.g., morbidity and mortality causes, available resources, regional variations, etc.) which needed to be considered when molding a health delivery system which a government could support. Many meetings were held during the initial years of the project between MSH planners and MOPH (AHC) and RHA health officials. What was missing -- as was the case in the planning of training, as noted above -- was that rarely were other donors included in planning sessions. There were various reasons for this. In the early years of the project, the UN agencies involved, importantly WHO -- the agency which generally takes on the health services development/standardization role -- arrived in Peshawar only in early 1989, and it was very weak. WHO also had a staff in Kabul, reportedly a larger and more competent contingent, which worked with the Kabul-based government. In 1991, WHO, to its credit, did get the two MOPHs together. Over a series of meetings (although they never met face-to-face) a master Five-year Health Plan for Afghanistan was hammered out. This was a notable achievement. This five-year Health Plan contained everything under the sun and certainly is not affordable. However, it has some excellent sections on basic primary health care, which was the product of the Peshawar-based MOPH, and was directly the result of the management/planning training by MSH under the HSSP.

MSH also made notable contributions in assisting the establishment of functioning regional health administrative entities, particularly in northern and central Afghanistan.

### *Health Services Implementation*

This was the heart of what the HSSP was initially tasked to accomplish: set up functioning health delivery systems, fully staffed and functioning -- and do it as rapidly and as well as possible.

At its peak, the project supported 5,363 health/medical workers and support people inside Afghanistan. These people staffed 2,271 basic health posts and 328 other health facilities (mainly clinics) plus administrative centers at the RHA headquarters. At the end of the project only 982 basic health posts and 1,905 personnel remained.

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There was a maldistribution of health facilities and personnel -- when taking other donor efforts into account -- towards the eastern sections of Afghanistan. This was due to the ease of accessibility to Pakistan and to the influence of the Pashtuns on the decision-making in the location of facilities and staff. (There may have also been political/military reasons for placing emphasis on the eastern part of the country.) MSH recognized this maldistribution and did place later focus in assisting in a more even distribution of assistance. To do this, MSH worked closely with the RHAs, particularly with the Supervisory Council of the Northern Area (SCNA) and the Health Committee of Central Afghanistan (HCCA), in northern and central Afghanistan. A major accomplishment of the project was to strengthen these two RHAs, and to a lesser extent, the regional health administration for south-southwest Afghanistan, based in Herat, to establish and run independent health delivery systems.

What MSH overlooked, was the fact that many health facilities --again including those supported by other donors -- were often serving the same communities. Redundant clinics were more often found in the eastern and northern parts of the country. Although this "rationalization" of facility/health worker location was the responsibility of the Health Services Development and Services Implementation departments -- and MSH was well aware of the problem -- MSH had the attitude that "we were there first," and nothing was done about this serious problem of wasted resources until USAID conducted a redundancy study and mandated cancellation of redundant clinics.

Health Services Implementation established an effective system for warehousing and transporting medicines and supplies to the hundreds of facilities throughout the country. The system relied on Afghan entities and commercial transportation. Aside from being more cost effective, it proved to be a safer way of delivering goods: MSH rarely suffered robberies, which was not the case with other entities supported.

MSH established an elaborate system of monitoring. This was done in collaboration with the MOPH and RHAs -- which had their own, nascent monitoring setups -- but the monitors worked directly for MSH. Almost all facilities and personnel were visited at least once during the LOP. (This was compliance, not technical monitoring.) Feedback from the monitors was slow in coming -- for a variety of reasons, most not under the control of MSH -- thus actions taken as a result of monitoring findings were sluggish.

### *Maternal and Child Health*

In a fairly short time period -- two years -- MSH established 41 MCH health centers and 22 health posts. Independent project evaluations, and USAID, pushed for a project focus on MCH interventions (which includes EPI and is dealt with in the next section). The MCH emphasis did not just rely on fixed facilities but also, to a large extent, based delivery of simple services on village-level providers: dais and volunteer health sisters. Many important services were delivered including a rapidly increasing spread of family planning services. MSH was probably the only implementor providing family planning devices and services.

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Since early 1992 USAID would not approve any new non-MCH facility or the hiring of any new male health workers. Then, MSH and the governmental entities it worked with, concentrated on the establishment of new MCH facilities and rapidly staffing these facilities with females, usually hired from the urban areas. The personnel hired were often poorly trained within the former communist medical education system. The expansion of MCH facilities and personnel by MSH was too hasty. It soon became evident -- from independent (USAID and other non-MSH) monitoring reports -- that the quality of many of the established MCH centers and personnel were below par. USAID determined that the quality of staff and the level of services delivered needed to be upgraded before any new MCH clinics were established. MSH never seemed to understand this decision by USAID, and, until the end of the project, questioned our motives.

Overall the HSSP made a significant start and a major contribution to turning Afghan health care towards women and children in a very short time period. MCH, it must be noted, was the basis for the proposed follow-on project. This was approved by Washington as part of the new strategy for Afghanistan; however, the decision to end the program cancelled our belated but excellent beginning to bring more care to the neediest part of the Afghan population.

### *Child Survival and Disease Control*

MSH perhaps made its most significant accomplishment in the establishment of an EPI delivery system that accounted for immunizing up to 40% of all the Afghans being vaccinated during the span of the HSSP. A strong EPI unit was established at the MOPH and two of the RHAs. A well-run cold room and EPI training center were set up in Peshawar and an effective cold chain system, with vaccine storage facilities, was put in place in most parts of the country.

Support was withdrawn from less than 25% of the field EPI personnel -- a very low cancellation rate given the wartime conditions. Both the MOPH and RHA granted their EPI managers a large degree of autonomy in the day-to-day management of operational and support activities, which may have accounted for the low non-performance rate.

Because of the time lag in reporting immunization data from Afghan project sites, there was a significant difference between actual immunizations given by a certain date and actual targets for that date, although most targets appear to have been met.

MSH worked closely with UNICEF during the years of HSSP implementation and, hopefully, UNICEF will be able to continue the HSSP EPI program (close to 200 immunization teams) in the future. USAID presently (5/94) is in the process of granting close to \$2.0 million to UNICEF to help continue EPI -- this is the last (and only FY94) USAID obligation for Afghanistan.

MSH established five pilot Tuberculosis centers, although one was cancelled for poor performance. TB is a serious problem in Afghanistan. Our effort was a token gesture; USAID did not authorize expansion given the limited project resources.

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### *Procurement and Supplies Management Service*

In simple numbers, MSH did a tremendous job in planning for amounts and kinds of medicines and supplies needed, placing orders, inventorying, packaging, delivering and accounting for a prodigious amount of materials: over 1,800 metric tons of medical supplies were shipped; over 13,000 medical kits were delivered to Afghanistan during the LOP. In addition, 39 supply management personnel were trained.

Of the health sector groups that USAID supported, MSH had the only system of quality control for procurement of pharmaceuticals. MSH was a member of the Coordination of Medical Committees (CMC) which did the initial work on standardizing the drugs and supplies for clinics and BHWs. The first standardized lists were developed in late 1988; however, MSH did not follow this system. It was not until late in the project, 1992 -- and under strong pressure from USAID -- until MSH did standardize on the medicines and supplies provided. MSH played a leading role in that it procured and packed in standardized kits for all of the USAID-supported health implementing entities. This was significant, as MSH had the only quality assurance system in place.

### *Finance*

More importantly than the successful expenditure of close to \$52 million dollars during the LOP, MSH's Finance Department made significant contributions in training Afghans in fiscal responsibility. This was not an easy task, given the cultural perception of accountability; however, those trained are available to plan and implement health services both from Kabul and from the regional health administrations.

MSH helped the Afghans to set up creative payment systems, to assure that funding was available when and where it was supposed to be in order to keep project implementation on-going, on schedule. Very little money was lost during the LOP. This, in itself, was a major accomplishment, given the "wild west" atmosphere of Afghanistan during times of war and civil unrest.

## **6. SIGNIFICANT LESSONS LEARNED**

- The HSSP clearly showed that **extensive medical services can be rapidly and effectively delivered to most populated areas of Afghanistan in a time of war.** That this was managed by "remote control", from across the border in Pakistan, makes it even more of a significant accomplishment. One must keep in mind, however, that this accomplishment speaks to medical services provided in a relief - - as opposed to a development -- program. Relief assistance was the original mandate given to MSH.

- **In a war environment one initially believes that much of the medical needs of the community would be directly war-related. This proved to be not true in the Afghan context.** The magnitude of injury-related deaths were far outweighed by deaths resulting from diseases which are typical in the third-world, many of which could be prevented by public health measures.
- **It is essential that the donor(s), in this case USAID, insist on coordination of efforts with other donors and/or implementing entities.** This is needed to assure standardization and avoid the duplication of services. One could offer many examples of errors made in this area during the life of the HSSP. Two will suffice:
  - (a) There was no coordination of the immunization program until very late in the program. This led to a gross wastage of effort and assets -- in some areas many groups were active, duplicating efforts leading to upwards of 100% more expensive vaccines being administered to a given geographic population than was needed. The donors have the primary responsibility for requiring coordination, but MSH also had a clear responsibility to see that coordination took place.
  - (b) There was no standardization of training courses, nor agreement on curricula or types of health workers needed for the country. The numerous groups went their own ways in producing health workers for Afghanistan. This is what can and does happen when there is no governmental body providing its needs or desires -- whether one agrees with them or not. WHO did not attempt to rectify the situation. This is being dealt with now, but the disparate varieties of health workers and quality of training they have received will be a nightmare for any future Afghan governmental health planners. Again, the donors -- particularly the UN, but also USAID -- had responsibility for guarding against the creation of such a sorry situation.
- **It is important for USAID to concentrate on a narrow number of interventions.** USAID's initial mandate to MSH was to "aggressively implement" health/medical assistance -- presumably, in part, to "win the war," although this was never stated as such. This is too broad a goal. One can, with validly, question whether pouring tons of medicines and supplies into Afghanistan is better at "improving the health of the Afghans" (or winning the war) than a more narrowly focussed program concentrating on the real health needs of the Afghan people. To be sure, it is easier to pour in the perceived relief needs by the ton, but is it any better than trying to do rehabilitation? It is surprising to this author how little is left of our almost 8 year, \$52 million effort under the HSSP at the end of the project. Certainly we and MSH could have done a better job!

(Note: Read MSH's final report. Each section presented a "Lessons Learned" writeup, many of which are important.)

## 7. SUSTAINABILITY

It must be understood that sustainability in any form was not a goal of the project during its very early stages of the project; financial sustainability was not an objective during most of the project; and, institutional sustainability only came to the fore in the late 1988 amendment to the AAM.

The initial mandate was "aggressive implementation." MSH will quickly give this mandate as a reason that earlier efforts were not made to put in place, or at least attempt to construct, systems that would remain after the project ended. The fact remains, however, that early on -- certainly by early 1989 -- MSH was tasked with working with Afghan counterpart institutions, or helping to create such where they did not exist. This was done in the development of the Institute of Public Health, and in the strengthening of existing health implementing entities within the Regional Health Administrations. But will these institutions last? The answer is perhaps "maybe" in some cases.

Institutional sustainability is intertwined with financial sustainability, particularly in a country like Afghanistan where -- at best -- there would only be a weak, penniless central government. Financial independence underpins the survival of these institutions. MSH's final report (Training department) opines that the IPH will collapse at the end of the project. This is probably true and it is too bad because it is an extremely well qualified institution. What could have been done to give this institution a chance to survive? MSH should have attempted something. On the other hand, the Regional Health Administrations, certainly in the north, and likely in central and western Afghanistan do have sources of funding and appear not to be adverse to having their health workers charge fees. In these cases, the RHAs and a portion of their health facilities may likely survive.

In the case of the Ministry of Public Health, which at present resides in Jalalabad with remnants in Kabul, it was generally against implementing any revenue generation schemes. This came to the fore when the MOPH refused to send out orders to its health facilities to charge even nominal fees. (MSH was strongly encouraged by USAID to implement fee-for-services in supported health facilities.)

One can argue that MSH, one of the leading professional, international public health organizations, should have placed more effort towards developing sustainable aspects of the HSSP. MSH did "talk" about sustainability, and it did develop a management tool, "SUSPLAN," which included sustainability; but the simple fact was that SUSPLAN was an "academic" tool and was not followed up with down-to-earth efforts.