

MANAGEMENT SCIENCES FOR HEALTH  
AFGHANISTAN HEALTH SECTOR SUPPORT PROJECT  
Peshawar, Pakistan

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July 15, 1988

Mr. Tom Eighmy  
Office of the Aid Representative  
American Embassy  
Islamabad, Pakistan

Dear Tom:

Attached is the Third Quarter Report. Len Chang is in Australia on his R&R, so I have not included the Third Quarter Financial Report. Since I believe Larry Crandall would like the quarterly financial reports to be physically included in the Quarterly Progress Reports, I will include it in the Progress Report and send you three copies of the combined report after he gets back.

Sincerely yours,

*Bill*

William D. Oldham, M.D.  
Team Leader

THIRD QUARTER REPORT - FY1988  
AFGHANISTAN HEALTH SECTOR SUPPORT PROJECT  
APRIL 1, 1988 THROUGH JUNE 30, 1988

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TRAINING

Richard E. Johnson, BSN, MPH, Training Advisor

1. EXPANSION OF TRAINING

1.1 BASIC HEALTH WORKER TRAINING

The fourth Basic Health Worker training class, with a combined enrollment of 241 trainees, officially started on 9 April 1988. Originally it was planned that the fourth class would start on 26 March, but due to the late arrival of trainees from the southern regions of Afghanistan, the starting date was extended to 9 April. A total of 85 trainees from the southern regions of Afghanistan were enrolled in the fourth class.

The practical phase of training started on 1 June. For this clinical experience, trainees were divided between BHW Training Camp Teaching Clinics and Tanzeem hospital facilities. This phase of training continued up to 30 June. As a one week holiday was granted for Eid, the training period was extended one week i.e. to 7 July 1988. On 2 July the Training Center will begin testing all BHW trainees. A combined BHW Training Closing Seminar is scheduled to be held at the Training Center on 10 July 1988.

During the first week of BHW Class 4 training, action was initiated to collect baseline biodata from the trainees. Each BHW trainee was interviewed to ensure accuracy of biodata, as this data will be used by the Clinics Department for field operations. BHW biodata summary tables are presented in Annex

Recruitment for the fifth class, it was agreed by the High Council, would be according to a procedure outlined by Dr. Laumonier on 14 March 1988. (See Annex 5) BHW Biodata Summary Tables for BHW Classes 1 through 4 were sent to the High Council on 2 May 1988 to assist them with initiating action on the recruitment for the fifth BHW training class. (See Annex 1) The matter of recruitment was discussed with the High Council on 29 and 31 May 1988.

1.2 BHW TEACHING CLINIC PLUS CLASSROOM FACILITY

The BHW Teaching Clinics were functioning in all 4 Training Camps. Dr. Mubarak Shah has been assigned to work with the BHW training staff and in particular to monitor the activities of the teaching clinics. Dr. Mubarak carried out site visits to

each Clinic to review and reinforce the main objective of the clinic i.e. teaching BHWs, and to provide advice regarding documentation for the utilization of expendable supplies and resupply procedure.

Expenditure of drugs for each clinic has been tabulated according to patient registers "Green Book" and clinics resupplied as appropriate. A Teaching Clinic Resupply kit was ordered on 24 February 1988. However, as the delivery of this kit is still not complete (30 June 1988), it was necessary to locally procure, according to the approved drug list, a small quantity of clinic items. Without this supplement, the Teaching Clinics would have become nonfunctional.

NIFA has not yet started construction of this facility.

Jamiat informed MSH that their underconstruction Teaching Clinic/Classroom facility was nearly completed and requested the remaining balance (Rupees 15,000.00) of a Rupees 75,000 Grant offered for this purpose. A site visit by an MSH Consulting Engineering firm was carried out to evaluate the building and prepare a cost estimate. Based on this information, a second installment of the Grant was made through the AHC for a total amount of 70,000 or 94% of the authorized Grant. The remaining balance will be paid when the building is completed.

ANLF and Harakat Teaching Clinic buildings have been completed.

### 1.3 REFRESHER TRAINING

During this quarter the main action for the refresher training program was the appointment of Dr. Mianudeen Yaseeni as Director of Refresher Training for Doctors and Nurses. This appointment was effective from 1 June 1988. Two important positions remain vacant i.e. one Deputy Director, Doctor Refresher Training and one Deputy Director, Nurse Refresher Training. The High Council was encouraged to try to fill these essential positions as early as possible so that implementation may move forward. Dr. Yaseeni has been working to organize his office and he has proposed that a general meeting be held with the Tanzeem doctors who were requested to teach specific topics assigned during the Refresher Training Curriculum Development Workshop held in February 1988.

### 1.4 REGIONAL TRAINING CENTER

Based on a request channeled through Dr. Wasiq from Dr. Sahar, Regional Medical Officer for Commander Masood, a joint proposal (Dr. Wasiq & Mr. Johnson) for a Regional Training Center located

at Takhar Provincial Hospital was developed. In brief the proposal calls for establishing a Regional Training Center that would have the capability to train new Basic Health Workers, carry out BHW refresher training programs and begin working out a training program for women focused on maternal and child health care needs. The service area extends to those provinces where a mujahideen administration (Supervisory Council representing various Tanzeems) under Commander Masood has been developed. The provinces within the health service area are: Takhar, Baglan, Kunduz and Badakshan provinces. (See Annex 2)

Meetings were held with Dr. Wasiq and the Director AHC Training Center to coordinate the BHW Training. Two qualified doctors were recruited in Peshawar by Dr. Wasiq for the Area Training Center. These doctors were given a BHW training orientation and briefing by the Training Center and arrangements were made for them to gain some practical experience at the Jamiat BHW Training Camp. It was agreed that BHWs trained at the Takhar Center would be according to the curriculum and standardized training materials prepared by the AHC Training Center. A set of training aids, reference materials and equipment was acquired and packed for shipment to Takhar. This shipment will be issued to Dr. Wasiq when he and his team is ready to return to Takhar. (See Annex 3)

The estimated cost for establishing (capital investment) and running the Center for one year is Rupees 577,600.00. This amount was provided as an advance, according to guidelines set up by MSH/Peshawar Financial Management Section.

Monitoring program activities will primarily be through reports sent by the Regional Medical Officer or his representative. (See Annex 4)

### 1.5 BUDDY CARE TRAINING

A general meeting with In-Charge of BHW Training Camps, members of the Medical Subcommittee and Training Center staff was held on 21 April to review the Buddy Care Training Program. It was agreed that coordination with Camp Commanders was essential and that this coordination needed to be strengthened. Additional tents for holding classes were requested and supplied, as required. It was recommended by the group that an incentive be provided to attract mujahideen for this training. However, before determining whether incentives are needed, it was recommended that the first step would be to secure the full cooperation and support of the camp commanders. If additional training aids are required, this should be coordinated with the Training Center. However, each Camp has a Petty Fund which may be used for example to purchase materials for making splints.

Complete data regarding the number of Mujahideen attending the Buddy Care Training has not yet been received by MSH. Therefore the number trained during this quarter will be reported next quarter.

During site visits to the BHW Training Camps the Buddy Care program was reviewed and teaching observed. Trainers were conducting classes and trainees were able to answer basic questions.

#### 1.6 THE TRAINING CENTER

One of the major activities during this quarter was focused on preparing for publication the Basic Health Worker Training Manual. To accomplish this task a working group, composed of the principle trainer from each of the BHW training program, was set up. The working group meet regularly at the Training Center and a draft is now ready for final editing.

A number of additional TALC reference materials have been received for the Training Center Library and BHW training programs. Contact was made with the Asia Foundation/Islamabad and copies of various medical books were obtained for the Library and BHW Training Camps. Asia Foundation has stated as new medical books are received, copies will be sent to the AHC Training Center Library. Dr. Veggeberg, Orthopaedics Overseas, Inc. has made arrangements to send through IRC selected medical journals for the library plus a number of training video tapes.

Preliminary work on a health education strategy has been completed. The proposed strategy will be written up for AHC High Council discussion and action. The Center has been very busy with developing visuals which may be printed for use in the health education program. Up to this point 58 posters have been prepared. It is expected that the printing process will be initiated early in the fourth quarter.

The Preventive Medicine Department, Immunization Unit carried out a vaccinator training program at the Training Center and the closing session was held on 28 June at the Training Center. The Preventive Medicine Department is now housed within the Training Center. With this addition plus the planned expansion of staff for the Training Center, office space is inadequate. Two verandahs were enclosed for office space and the carport was converted into a reception room. These additions will partially solve the problem, however, as both the Training and Preventive Medicine programs grow, a new solution for the office and activity space problem will have to be found.

One of the priority objectives of the Training program is to carry out field assessments of the BHWs. This is needed for determining whether the training is achieving the desired results and to modify or adjust training according to field requirements. Some of the BHWs returning for resupply are interviewed by the training staff however, this cannot substitute for field observation and assessment. The High Council has been requested to send into Afghanistan four nurse trainers to observe and assess the technical performance of a sample of BHWs. The High Council during a meeting held on 30 June approved this request. A detailed assessment plan will be prepared by the Training Center early next quarter.

Based on expanding training program requirements, MSH offered (last quarter) to support four new positions in the Training Center i.e. Senior Administration, Editor, Curriculum Developer and Audiovisual Technician. The High Council accepted this recommendation, however, no appointments to date have been made. In addition, two positions for the Refresher Training program have not been filled. As this staff is urgently needed, the High Council has been encouraged to appoint staff to these new positions as soon as possible.

Recently Itehad or Sayaf Tanzeem became active members of the AHC. The Itehad Tanzeem requested MSH support through the AHC for establishing and operating a BHW Training Program at the Itehad Mujahideen Tanzeem camp near Pabbi. A meeting was held at the Training Center on 30 June with Dr. Mohd. Ibrhim and Dr. Fazel Mohd. to begin the process of implementing the training program.

## 1.7 OTHER ACTIVITIES

### International Medical Corps

Through the efforts of the IMC Training Coordinator, Dr. Sharon Mc Donnell, the AHC High Council and senior training staff were invited to visit the IMC Training Center at Nasir Bagh. A open discussion regarding the programs of each organization took place and tentative agreements were made for exchange visits between IMC Training Center and BHW Training Camps. These exchange visits have not yet taken place.

MSH, on behalf of IMC, communicated an IMC offer to train up to 27 medical technicians for AHC clinics inside Afghanistan during their next training program. MSH also discussed this matter with the High Council. Further action in this matter will be between IMC and High Council.

Mercy Corps International

MSH was requested to communicate the MCI offer to train up to 22 medical technicians in their next 6 month training program. This was, as for IMC, communicated to the High Council. Further action in this matter will be between MCI and High Council.

Save the Children, USA

Meetings between Dr. Wasiq and Save the Children were facilitated through the MSH Training section. An agreement between Dr. Wasiq and Save the Children was reached for initiating an income generating program for women in the area near the Takhar Provincial Hospital

Afghanistan Health Sector Support Project Evaluation Team

Site visits to the BHW Training Camps were organized for the team as well as meetings with the AHC Training Center technical staff and members of the Medical Subcommittee. The Training Advisor accompanied the Team on these visits and provided the Team with information and documents about AHC/MSH training activities.

FIELD OPERATIONS

Laurence Laumonier, MD, Medical and Field Operations Advisor

2. EXPANSION OF HEALTH SERVICES INSIDE AFGHANISTAN:2.1 Basic Health Workers:2.1.1 Departure of the third session of BHWs:

\* In mid - April the second group of BHWs (112 BHWs) of the Third Session were issued their kits of medicine, salaries and the cost for transportation for their supplies to the site of their assignment. This group had been held after graduation because they could not go inside in March because of the snow.

The following supplies had been prepositioned at the border for this group:

- 4,201 tons had been sent to the 4 Tanzeem Depots in AZAM WARSAK
- 1,013 tons " " " to Chitral
- 6,040 tons " " " to the 4 Tanzeem depots in MIRAMSHAH
- 2,888 tons " " " to the 4 Tanzeem depots in TERIMANGAL
- 0,525 tons " " " to Quetta by train to the AMEG warehouse.

All these shipments had been made under the supervision of one MSH monitor and one staff member from the AHC Supply Department. It is the responsibility of these employees to bring back the receipts for the issue of the supplies from the depots.

Two months after the departure of the second group of the Third Session, all the reports of the monitors located at the various points of entry, were collected and reviewed. Of the 239 BHWS graduated from the Third Session, the final report shows that:

- 60% (143 BHWs) were issued their supplies and crossed the border to go inside Afghanistan
- 30% (72 BHWs) had not request issue of their supplies or crossed the border.
- 10% (24 BHWs) had not been checked (21 BHWs of Quetta area, and 3 BHWs in Lantikotal).

The performances of each Tanzeem are as following:

- ANLF:
  - \* 41 had crossed the border with their medicine (= 69%)
  - \* 18 had not crossed the border (= 30%)
  - \* 2 had not been checked

HARAKAT:

- \* 48 had crossed the border with their medicine (= 80%)
- \* 8 had not crossed the border (= 13%)
- \* 4 had not been checked (= 7%)

- JAMIAT:

- \* 22 had crossed the border with their medicine (= 37%)
- \* 31 had not crossed the border (= 52%)
- \* 7 had not been checked (= 11%)

- MAHAZ:

- \* 34 have crossed the border with their medicines (=57%)
- \* 15 have not crossed the border (= 25%)
- \* 11 have not been checked (= 18%).

One of the major reasons of non-departure of BHWs is the lack of horses to transport their supplies (the horses have been used by the priority program of transporting military material). Another reason is that the BHW prefers to wait for his own group instead of going with another group. One other reason is the unwillingness of a few individuals to return inside Afghanistan.

The bad performance of Jamiat is partly due to the fact that 9 BHWs were supposed to go through Chitral; but the way was still not open for the horses due to the snow.

2.1.2 Resupply Operations:

Of the 161 BHWs of the second session initially supplied for 6 months last November, 66 BHWs came back to Peshawar to get their resupply; all of them have been interviewed by the Field Operations Advisor and Mr Taher, her assistant, and Eng. Najib, the Director of the AHC Supply Department.

142 other Resupply Operations have been done for BHWs of the First, Second and Third Sessions; these BHWs have been interviewed also and compared and combined with the results of the monitoring reports coming from the border and from inside.

2.1.3 Preparation for the departure of the 4th Session:

Coordination has been carried out with the MSH Training Department in order to get better data concerning the BHWs actually present in the 4th session, especially for their location of work and name of the commander who will have supervision responsibilities in the field.

Coordination has been carried out with the AHC Supply Department in order to know the point of entry which will be used by the BHWs when they return: one person of the Supply Department is

actually going to each Training camp to get this information from the BHWs themselves. The departure is supposed to take place after the 10th of July.

2.1.4 Preparation for the selection of the BHWs of the 5th Session:

Recommendations for the selection of BHWs for the Fifth Session has been written up by the MSH Field Operation Department and discussed with the High Council and the Medical Sub-Committee. The importance of making a selection based on population rate and on the provincial distribution of the graduates of the previous session was emphasized as was the need for the preparation of the selection of each session to be on time. (See annex 5).

Two meetings with the High Council has been held about the selection of the fifth session: the provinces which have been recommended as a priority are: Badakhshan, Badghis, Herat, Ghor, Helmand, Samangan, Uruzgan, Nimruz

2.2 Clinics:

2.2.1 Implementation of new clinics:

During June, after a long delay due to procurement problems, MSH/AHC were able to issue new clinics. Some of the requests were dated from beginning of February 1988.

From the 36 requests for clinics which were existing at the beginning of June, we were able to issue 14 clinics (these 14 clinics had been ordered last December 1987; at that time 14 clinics only had been ordered according to the budget of 10,6 millions dollars)

One of the main consequences of this long delay was that it has been practically impossible to put technical pressure on the AHC High Council for planning new clinics in relation to the provincial rate of population and number of clinics already set up by AHC and CMC committees (the personnel of the clinics had been waiting for too long a time). The AHC High Council decided finally to select the clinics according to the date on which they had been requested. The following clinics have been selected:

- 3 in Logar
- 2 in Kunar
- 1 in Baghlan
- 1 in Parwan
- 1 in Uruzgan

(Clinics selected cont.)

- 1 in Nangarhar
- 1 in Zabul
- 1 in Faryab
- 1 in Ghazni
- 1 in Wardak
- 1 in Kunduz.

Regarding the estimated populations of these provinces, this list of new clinics is quite good despite the clinics proposed for Logar and Kunar, where the population is not very high compared to the other provinces and where CMC and AHC have already established a number of clinics.

Indeed, an analysis had been presented to the AHC High Council, with comparing the size of the pre-war population of the provinces (census 1979) and the clinics already implemented by AHC and CMC. Another analysis has been made comparing the estimated size of the actual population of the provinces and the clinics already implemented by AHC and CMC. Three alternatives have been proposed: 1 clinic for 5000 inhabitants; 1 clinic for 15.000 inhabitants; 1 clinic for 30.000 inhabitants (see in annex). This analysis will be helpful for the next batch of new clinics (and for the selection of BHWs).

Among these 14 clinics:

- 8 have been provided to HARAKAT Party (which had not implemented a lot of clinics until now)
- 3 have been provided to JAMIAT Party
- 2 have been provided to MAHAZ Party
- 1 has been provided to ANLF Party.

The staff of these 14 clinics includes:

- 10 M.D.s
- 7 Diploma Nurses
- 12 Medical Technicians
- 5 Medical Students
- 4 BHWs.

Concerning these personnel, one uncertainty remains. Most of them are reported to be working inside Afghanistan and have not been interviewed by the AHC Medical Sub-Committee. This committee determines their qualifications by giving a thorough oral examination and study of the candidates documents, diplomas, etc. Several doctors have been appointed by AHC High Council to make this medical evaluation in the field, but until now, no one has gone inside Afghanistan to make this

evaluation. The only checking which is done at the present time is through the MSH Monitoring System which is able to check only the presence of the personnel in the clinics but not their medical competence.

At the end of the quarter, new requests for clinics had been applied by AHC for a total of 41.

### 2.2.2 Resupply of existing clinics:

Eighteen clinics have been resupplied during this quarter. For most of these clinics, one person of the staff came to Peshawar to get the supplies. The MSH Field Operations Advisor and the Director of the AHC Clinics Department, and one doctor of the AHC Monitoring Unit interviewed each returnee to get some feedback about the activities of each clinic, their specific needs, the coverage of the population, etc. They also obtained each clinic's green books whose data will be entered in computer for further medical analysis. For the time being, these interviews are useful to discuss with the medical personnel about their medical activities in order to show them that their collaboration on this matter is essential to understand better the medical needs and the pathology of Afghanistan, region by region.

These interviews are summarized through "Memos" to the MSH staff and particularly the Field Operations staffer who is in charge of the resupply operation.

The MSH Team Leader has agreed that tents and/or bicycles can be provided to the clinics in those cases that a special circumstance makes them necessary.

### 2.3 REGIONAL HEALTH SYSTEMS:

2.3.1 During this quarter, Dr Wasiq, representative of Dr Sahar, Health Regional Officer of the North-East Area of the Supervisory Council of the North (Baghlan, Badakhshan, Kunduz, Takhar) has been visiting regularly the MSH office to have technical discussions with the various members of MSH staff about: training, field operations management, clinical management, medical supplies and equipment needs, medical administration & management, and financial management.

He has completed his report as a short-term consultant. These discussions have been very useful to understand the development of regional health systems which are actually taking place inside Afghanistan.

MSH agreed to support:

- the "provincial" hospital, located in Takhar province
- The staff of the administration unit.
- the staff of the logistic unit
- 8 clinics
- 1 training center for BHWs.
- 3 drills

Several meetings for coordination of donor inputs have been held with the CMC committees who have been requested by Dr Sahar and Dr Wasiq to support their activities. The following committees were usually present:

- MSH
- Swedish Committee
- Norwegian Committee
- Freedom Medicine
- IMC
- Medical Coordinator of the CMC.

A standardization of salaries for medical technicians has been accepted by MSH and the CMC. Most of the medical technicians are trained by the member organization of the CMC. Further discussion between CMC and AHC should be held for standardization of the salaries of other personnel of Health (nurse, doctor etc..)

Some of the items that Dr. Wasiq had asked MSH to provide were shifted to the Norwegian Committee (generators, motorcycles, water pumps and small cameras, and typewriters) and MSH took over the procurement of TB drugs from the Norwegians by mutual agreement, since MSH was better equipped to make this purchase.

2.3.2 Jelalludin Haqani, the famous commander of Mollawi Khales, has formally invited the team of MSH to come to visit his camp in Miramshah where a training center could be established to develop health services in the 5 provinces of Wardak, Paktia, Paktika, Logar, Ghazni. During the next quarter, MSH will ask the Health Chairman of Khales Party to join the team to go there.

2.3.3 MSH got news from the Regional Health Officer of the Western Provinces, Dr Mahmoud Shah, under the command of Ismael Khan, that all the medical supplies and equipment did arrive safely in the area.

### 3. MONITORING SYSTEM:

The monitoring system of the border showed the percentage of BHWs of the third session who have left the border with their medical supplies (see results 1.a). They also check the departure across the border of any personnel transporting the resupply commodities of BHWs and Clinics.

The Medical and Field Operation Advisor recently made a trip to Quetta in order to set up the logistic system in this area and to implement a monitoring system on the border at the main points of entry into Afghanistan.

She also coordinated with the AMEG warehouse where all the medical supplies will be sent from Peshawar. A MSH Logistic Quetta Coordinator has been employed to send these supplies to the border with the cooperation of the GOP. On the border the AHC/MSH program will use the depots already set up by MCI. The MSH Quetta Logistic Coordinator will select two monitors on the border to be employed by MSH/ Peshawar office. The Logistic and Monitoring Unit has been developed in the area of Quetta before the departure of the 4th session of BHWs (82 BHWs have been selected from Quetta area).

Deployment of many teams of monitors inside Afghanistan has taken place during this quarter because, of course, it is the best season. Fifty-two monitors have been sent inside, in teams of 2 persons to cover 10 provinces. Each team has an average of 20 to 25 BHWs to check. (See Annex 7)

MANAGEMENT AND MANAGEMENT DEVELOPMENT

Anibal Mejia, MPH, Senior Management Advisor

4. MANAGEMENT DEVELOPMENT4.1 INFORMATION SYSTEMS MANAGEMENT

The 1988 Second Quarterly Report established that Management Information System had two nexus: External and Internal. The Internal link encompasses data related to project work program activities while external data or conditions might impact the delivery of services inside Afghanistan. Because, as environmental factors, external conditions might impact on project design, and operation the following constraints are observed.

4.1.1 Internal Management Information System links

Internal Management Information System links include the information relationships between Alliance Health Committee and MSH/P activities in pursuit of work program accomplishments. These links have been depicted in the MIS relationship diagrams published in earlier reports and constitute the bulk of program indicators which are enhanced or emphasized during a given time period or another. Summaries of Basic Health Worker characteristics, for example, are made in order to sharpen BHW selection relative to Province, Region or Area. Monitoring data will be summarized and contrasted to AHC activities in order to assess impact on given areas. "Greenbook" information is being gleaned in order to obtain morbidity information relevant to program planning.

During the present quarter various data handling activities were consolidated by the formalization of a Data Processing Unit charged with the responsibility to enter, edit, report, and conduct preliminary analysis of batch program data. The Data Processing Unit concentrated on Data entry from the 96 available Greenbooks and the implementation of the Warehouse Data Integration module by completing the computerization of stock cards. The former data entry paves the way for initial editing of clinical data for subsequent analysis on a progressive ten percent sample of clinical records by province, patient population, including all health service provider types. First edit runs should make it possible to correct spelling mistakes and re-code health problem and prescription categories in order to facilitate cross-matching of information. After the second edit runs are complete morbidity rates per region should be able to be gleaned from the data. Obviously this is a time consuming task made a little more onerous by the CMC's decision to change to RBase. (This move is discussed in the next section.)

The completion of the warehouse stock card project will help immensely in anticipating procurement needs, order sequencing, and determining stock levels instantly. It also will assist in developing net forward reporting which will facilitate warehouse management. (Please See Chart on Integration Warehouse/Procurement.)

#### 4.1.2 External Management Information Links

The absence of definitive population estimates has been deplored as a stumbling block in the planning of services to be provided in Afghanistan. The impact of services supported by other donors and "committees" must also be taken into account in order to optimize resources. For these and other reasons the information system must take into account external factors that bear upon MSH/P supported activities. The effort to consolidate demographic assumptions was frustrated by the slow pace of Organizational Development at the AHC. While there were substitute progress milestones on other kindred areas, the Task Force on Population was not addressed during the period. The inclusion of reasonable population estimates is nevertheless the key to rational program planning and will be pursued as a decisive environmental factor. The stature of the Swedish Committee must likewise be taken into account as part of the external environment. Finally a cooperative relationship with other organizations has been similarly pursued by establishing a viable data standardization procedure with smaller agencies represented in the Coordination of Medical Committees (CMC).

Technical Assistance provided to the Swedish Committee last quarter relative to computer services design was followed up with additional logistics and procurement assistance provided by MSH/Boston. During the next quarter local assistance will be offered to the Swedish Committee relative to the establishment of its computer service.

The inter organizational cooperation on service statistics available through the CMC was formalized by efforts to assign staff to the task. A summer graduate student intern expatriate was assigned to supplement local volunteer organizational resources. This move is very positive since it creates a division of labor within the CMC. However, the lack of DBase software knowledge at the CMC was supplemented by bringing an additional resource into the situation: A TDY Consultant. By virtue of this consultant's intervention software changes were made to RBase which brings another factor to be dealt with. RBase is thought to be much more "user friendly" and more suitable to the computer skill level available at the CMC. While the the software systems are translatable it is not known yet

whether or not, or to what extent, data analysis will be affected. The CMC is proceeding with data entry from various smaller organizations and a meeting will soon be held to determine if the Swedish Committee data can be contracted to be processed by the CMC.

#### 4.2 BUDGET AND BUDGETING

MSH/P created a program budget as a means to deal with the project's peculiar project paper situation which was originally based on divergent costs, exacerbated by substantial inflation and changing program implementation strategies. This budget system had a number of redeeming qualities since it made it possible to estimate expenditures at various rates of program implementation. However, Fiscal budgets are still necessary for a number of administrative applications and a means of translation was required at two levels: One, at the day to day accounting level for routine expenditures and, two, at the global planning and design level for program implementation assumptions. The former will be the subject of follow up by the MIS short term consultant while the latter was developed during this quarter. The former utilizes the DBase software program while the latter utilizes a spreadsheet format.

The development of the translation facility at the global level was fortunate since the Project Evaluation Team on site during the latter part of the quarter utilized this format in order to assess the validity of program and financial decisions. Utilizing reviewed costing factors the budget was updated during this time to corroborate budget utilization assumptions.

#### 4.3 ASSISTANCE TO THE PROJECT EVALUATION TEAM

Two person weeks were required of the Senior Management Advisor during the Project Evaluation team stay in Peshawar during the quarter.

#### 4.4 THE WAREHOUSE SERVICE

As promised, the MSH/P warehouse renovation project and moving activities were completed by April 15, 1988. Program expansion in the immunization area, however, required additional floor space and the USAID/REP'S office authorized it for completion at the end of July 1988.

Warehouse activities are now much more comfortable and systematic. Along with the physical improvements it was decided that a review of critical procedures and physical environments subject to industrial standards should take place. Thus, an in house review of procedures and environments was conducted in order to identify areas needing improvement both in repackaging as well as storage of goods in the warehouse. This review is documented for future reference and has become part of the Warehouse Operations Manual.

The Warehouse Monthly Goals were projected for an entire year in order to facilitate project procurement planning. Previously these goals were projected on a quarterly basis. These include administrative and production goals and are reviewed during the Warehouse/Procurement Task Force weekly meetings.

During the quarter 3,000 cartons were issued weighing 41 metric tons; while another 2,800 cartons were assembled for clinics and basic health workers weighing 40 tons.

#### 4.4 ALLIANCE HEALTH COMMITTEE

AHC negotiations were completed with regard to the substitution of a full time Chief Executive Officer with the combined team of the changing President of the Council and four Executive (Professional) Vice Presidents. By the end of last quarter the Alliance had filled most of the positions called for in the Organizational Development Plan.

The Alliance Health Committee underwent another quarterly change of President. This presidency has given most of its attention to the accommodation of the Sayaff and Khalis Parties. Sayaff's being consummated by the end of the quarter, while Khallis' still remains "practically in the wings". It has been evident that the two weekly meetings, as well as extraordinary meetings, have been devoted to the inclusion of these two political parties. Regrettably these positive results have slowed other aspects of organizational development mostly by precluding the appointment of the Executive Vice Presidents. The lack of Vice Presidential appointments in turn retard the formalization of organizational and departmental objectives and the drafting of job descriptions for key employees.

Nevertheless, high level meetings have made for an opportunity to point out the cumulative impact of the indecision and promises for quick and definitive actions have been obtained. Obviously, the prospects of additional party participation have impacted the High Council into more activity which is salutary. Greater individual participation has been noted and while delicate negotiations take place the over all result is one of apparent satisfaction.

#### 4.5 PERSONNEL MANAGEMENT ACTIVITIES

Following the decision to increase the work force by including program assistants as intermediate managers to the staffing pattern, a number of integrating activities were conducted. These included the study, design, location, classification and drafting job descriptions for the following positions:

Program Analyst, Supervisor, Data Processing, Local Purchasing Agent, Medical Supply Procurement Officer, Training Assistant/Medical Officer, Quetta Logistic Coordinator.

Job descriptions were also processed to include within the classified personnel scheme the Security Supervisor and the Security Guards.

PROCUREMENT

Paul Eckx, MD, Associate Medical and Procurement Advisor

3. PROCUREMENT SERVICES

5.1.- Survey multinational pharmaceutical firms.

Mr. Riaz Ahmed Khan, continued the work of Mr. Burton. Between 25 March and 9 May he audited 17 manufacturers for GMP and GLP. During his audit he observed the same standards as Mr. Burton. In his report, he gave a detailed evaluation of all points of critical value.

When a certain line of products was definitely not acceptable, Mr. Khan made sure to identify exactly the products involved. MSH knows exactly what products are acceptable from each of the inspected firms.

Care was taken before his arrival to list enough firms, to cover as much of the MSH drug needs as possible. However, some manufacturers dropped out at the last moment and some of the approved manufacturers did not manufacture all products they had a licence for. Cfr. report.

In order to fill the gap provoked, Mr. Khan will come back to audit some additional manufacturers in the beginning of July.

5.2.- Staff expansion.

Mr. Najam Lone has been added to the staff as Medical Supply Information/Procurement Officer in order to assist the Associate Medical Advisor with managing the MSH medical procurement since the first week of June.

Job description in Annex 8.

5.3. Inventory quality control procedures of drugs and equipment

Visits to the Warehouse have become more regular. Mr. Lone visits the Warehouse two times a week, or whenever the Warehouse Manager thinks necessary, to assist Warehouse Manager in the process of quality control of received goods.

He is also advising on repackaging and storage practices (Annex 9).

5.4. Flow stream between AMEG and MSH

Working relations with Mr. Tom Hatsokano and Mr. Iqbal and Mr. Safer are good.

Despite efforts from both sides to increase and improve communication, the extremely difficult telephone connections between Islamabad and Peshawar and the availability of only one line in MSH-office prove to be insuperable obstacles. Use of telex (through USAID/Peshawar) was a solution in some cases, but any subject requiring communication for more than two, three minutes requires physical displacement of either MSH- or AMEG-staff.

#### 5.5. Bulk procurement and course of therapy packing (CTP).

The timetable of Field Operations requirements, put on dbase in the previous quarter, has been updated continuously. It has made possible to estimate requirements for output from the warehouse, delivery at the warehouse, purchasing, and ordering taking into account the various lead time requirements.

Uncertainty about funding restrains MSH from going ahead and placing a bulk order up till September 1988, with partial deliveries on basis of monthly requirements. (Annex 10)

A problem, recently being looked into, is the performance of the Pakistani pharmaceutical industry. Already, the bulk of some of the items on MSH order requests surpasses the annual production of some of the former suppliers. In deliberation with AMEG, possible solutions for this problem, that will only increase as the program expands, are being considered.

CTP at this point seems not feasible for all drugs : rapid program expansion asks to much effort from Warehouse personnel. However, as soon as additional space becomes available, a test can be implemented with those drugs that have to be repackaged anyway (e.g. Tetracycline).

#### 5.6. List for Hospital.

The order for District Hospitals has been placed.

The lists for Provincial Hospitals has been completed, drawing upon information regarding needs from Dr. Wasiq, representative of the Regional Responsible of Health Dr. Sahar. Dr. Wasiq's experience in the provincial hospital of the Supervisory Council of the North and his demands for resupply, gave updated information to finalize the Provincial Hospital medical supply lists.

### 5.7.- Regular review of medical supply lists with Medical Sub-Committee.

Changes in the supply lists have been discussed with concerned parties. Demands for changes in the drug lists for the training camps are first evaluated by the Medical Subcommittee, before discussion with MSH.

### 5.8.- Cost monitoring

The expensive items mentioned in the previous quarterly have been totally or partially replaced (e.g. mebendazole, furadantin, Actifed, benzathine penicillin, ...).

Cost per facility and relative cost of drugs, expendible medical supplies and medical equipment are being monitored. Annex 11.

## 6. PREVENTIVE MEDICINE DEPARTMENT

### 6.1.- Immunization Unit (IU).

Of the final composition of the IU agreed upon by the High Council following positions have been manned :  
One Director (Jamiat), the overall director of the Preventive Medicine Department, Dr. Basir Sahel, M.D. He is also vice-president of the Health Committee of Jamiat and member of the Medical Sub-Committee.

One Assistant Director (ANLF), Mr. Rahmanyar, agricultural engineer.

One Educational Manager (NIFA), Dr. Quraishi, M.D. graduated in 1985 from Kabul University as O.R.L. specialist.

One Education Assistant (ANLF), Mr. Safi, graduated pharmacist with more than ten years teaching experience in various medical institutes.

One Assistant Logistician (Jamiat), Mr. Hashem, vaccinator before the war and responsible of vaccinations in the Jamiat Hospital.

One Field Operations Manager (Harakat), Dr. Mohamad Jamil, M.D.

Until now Harakat has been unable to provide the name of the Logistics Manager.

The decision to put the IU in the same building as the Training Center proves to be useful. While starting up, the IU could draw upon the experience of the Training Center staff, especially for defining its own responsibilities as a technical unit in the total administration of AHC.

The High Council has been unable to decide on the salary for at least two members of the IU, who temporarily are getting a fixed remuneration.

Although members of the IU are interested in their job, the fact of being appointed to their duties while the vaccinator training was already starting, has prevented them from being prepared to take their full responsibilities in the training of the first session of vaccinators.

The members of the IU took profit of the assistance of AVICEN in the training to refresh their personal knowledge about immunization.

#### 6.2.- Vaccinator Training.

The training of the first session of vaccinators was largely conducted by AVICEN, with the members of IU actively assisting. The selection process has been described in the previous quarterly report.

Twenty four trainees, six per party had been selected. A weekly allowance of Rs 200 only had been decided upon. This allowance covered all expenses of the students going back and forward between their respective residences daily. A special ID has been delivered by AHC to enable the students to prove the necessity of their circulating in Peshawar on course days.

The vaccinator course took place from Saturday through Thursday. Starting at 8.00 AM with theoretical sessions for all 24 students. Afternoons were dedicated to demonstration sessions and workshops in small groups, covering different aspects of immunization. A syllabus, in Dari was handed out during each lesson, to enable students to review at night the topics covered each day. The following morning, the new session started with a short oral exam of some student covering the topics of the previous day.

During Ramazan, courses started at 7.00 AM, to finish at 1.00 PM. After a preliminary exam, practical vaccination sessions under supervision of IU and AVICEN were conducted in various party health facilities, and mobile campaigns, in cooperation with the existing EPI program for Afghan Refugees, in the camps of Mattani and Khorasan.

The organization of the practical sessions proved more difficult than foreseen, due to Ramazan and consequent Eid holidays. Training was prolonged to ensure enough practical experience for each group of vaccinators.

One student, introduced through NIFA, belonging to the Shura ye Ittefaq, was called back to Afghanistan by his commander before the end of the training.

After the final exam three students proved to be too weak. They were given a second chance after reviewing some of the points they failed. And two of them succeeded in passing the next exam. One student, again from Shura ye Ittefaq was ambushed and killed with four of his fellow travellers, coming back from the border for the graduation.

On 28 June a small graduation ceremony concluded the first Vaccinator Training Session.

### 2.3.- Training of Immunization Managers.

From the start, attention was paid to the refreshing of the members of the IU, in order to provide them with the knowledge necessary to fulfill the responsibilities described in their job description.

As mentioned, a big handicap was the fact that the IU had not been established two months before the first vaccinator course started, as was originally planned. Active participation in the daily courses and workshops was agreed upon between IU, MSH and AVICEN as the most feasible strategy.

At all times AVICEN staff was available for consultation by the IU members.

A weekly meeting on Thursday between MSH, AVICEN and IU formalized the exchange of information. Difficult points, problems encountered, differences of approach were discussed and solutions agreed upon by the three parties.

AVICEN and IU mentioned the difficulty of getting in contact with MSH by telephone, which delayed certain decisions, e.g. transportation to and from refugee camps for practical training. Eventually, during the practical sessions outside the Training Center, a Tuesday planning session between AVICEN and IU helped overcome logistical difficulties more smoothly.

A weekly Sunday meeting was also held between MSH and IU, where more managerial, administrative and planification topics were covered.

The initial misunderstanding that the IU was only responsible for training, took some time to overcome. The IU members seemed to have a lot of difficulty to define the degree of decision making delegated to them in order to assume fully their technical responsibilities. However, at this moment a clearer distinction seems to have been made between technical (and consequently IU related) and policy-making (and consequently High-Council related) matters.

At the explicit request of the IU, close cooperation with AVICEN will continue on a personal services basis. AVICEN staff will continue to assist the IU for specific technical problems, until IU has acquired the necessary knowledge and/or supplementary staff to solve all problems autonomously. A search is being made for an electro-technical engineer to maintain and repair cold chain equipment.

Regarding the preparation of the departure of vaccinators to the different target areas inside Afghanistan, the IU lacks at this moment the necessary technical skills to take full responsibility of this process. On 25 April a meeting was organized between IU, president of AHC and the responsables of the target regions. Dr. Nageeb and Dr. Basir gave a concise briefing on the coming vaccination campaigns and the responsables of the logistics for the target areas promised their cooperation when it was needed. Immunization cards and records have been prepared and are being printed.

As planned, vaccines and injection material were obtained from UNICEF to assure congruency with other agencies carrying out immunization campaigns and relying on UNICEF for those supplies.

#### 6.5. Other Activities of Preventive Medicine Department.

Discussions have been held regarding possibilities of implementing :

- tuberculosis control program
- malaria control program
- Maternal and Child Health programs

Only malaria control programs and MCH seem to be feasible in the near future. However, the starting up of successful immunization campaigns has been given priority until the second quarter of Program Year III.

Implementation of a tuberculosis control program has been discussed extensively with the Italian Cooperation for Development, in charge for the Tuberculosis Control Program among Afghan Refugees in the whole NWFP.

A nation wide program is not feasible at this moment. A small pilot program will be started in the North East, where Sahar's Health Administration gives some warranty of organized follow-up of the patients. This small program can be monitored for conclusions regarding feasibility of expansion in the same region or elsewhere. Annex 7.

## 7. GENERAL MEDICAL ADVICE

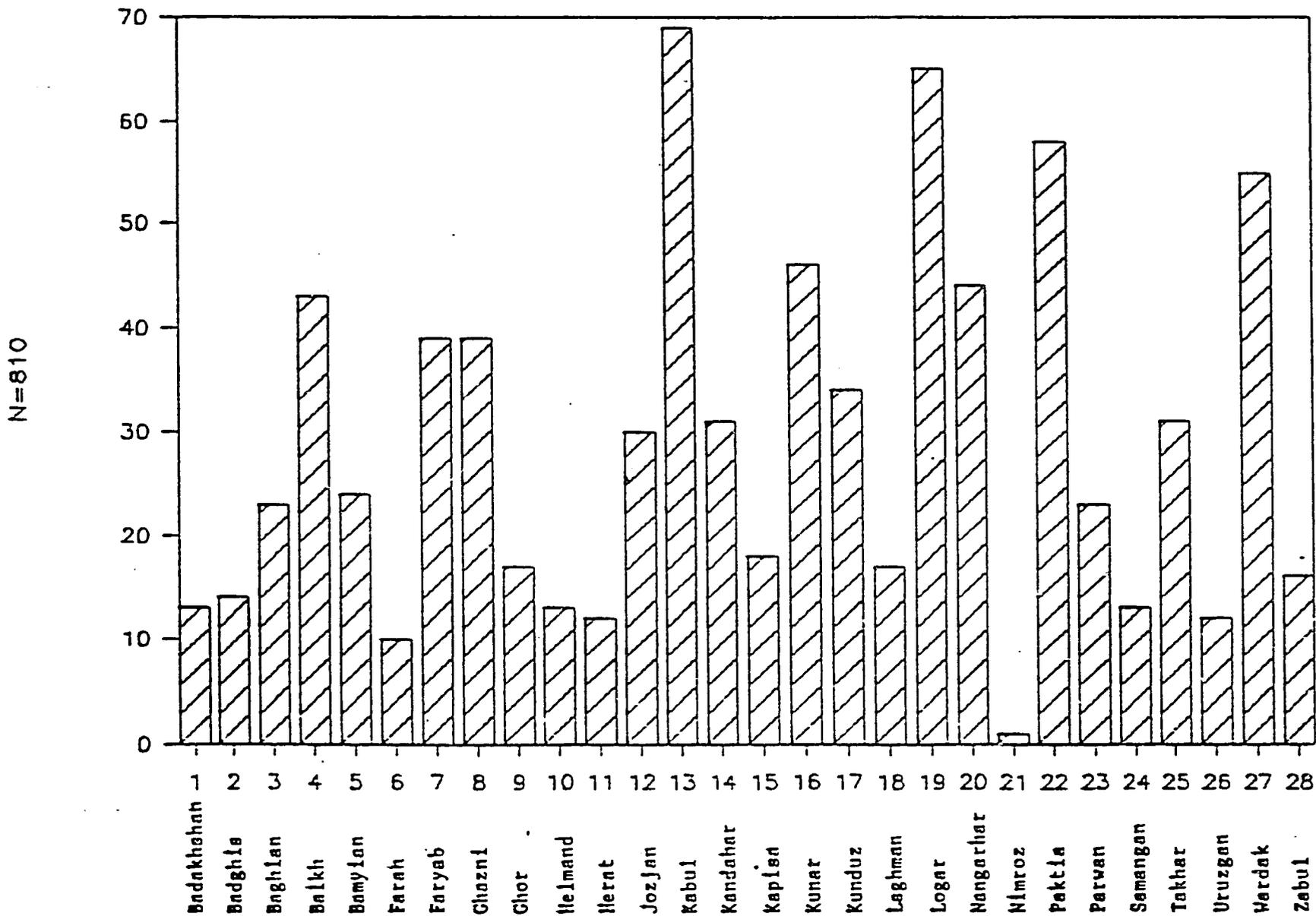
Trials to survey available material on existing health facilities and activities inside Afghanistan have been made and put down in far from complete summaries. Annex 8 and 9.

Together with Field Operations some estimations have been made regarding existing and needed health facilities according to population under different scenario's (no, partial or complete return of the refugees). Cfr. Field Operations.

ANNEX ONE

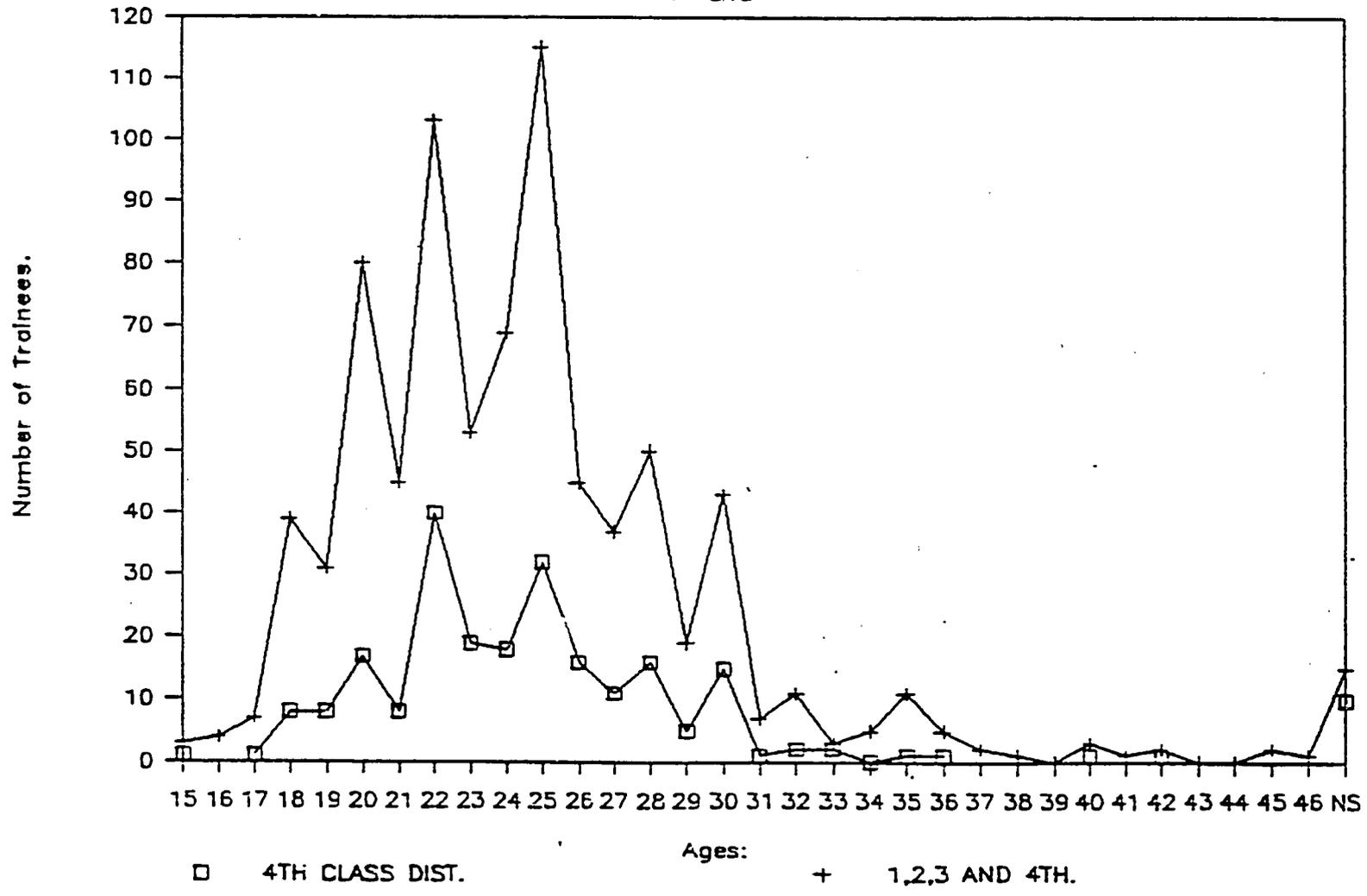
BHW Biographical Data Tables \*

# PROVINCIAL DISTRIBUTION FIRST 4 CLASSES



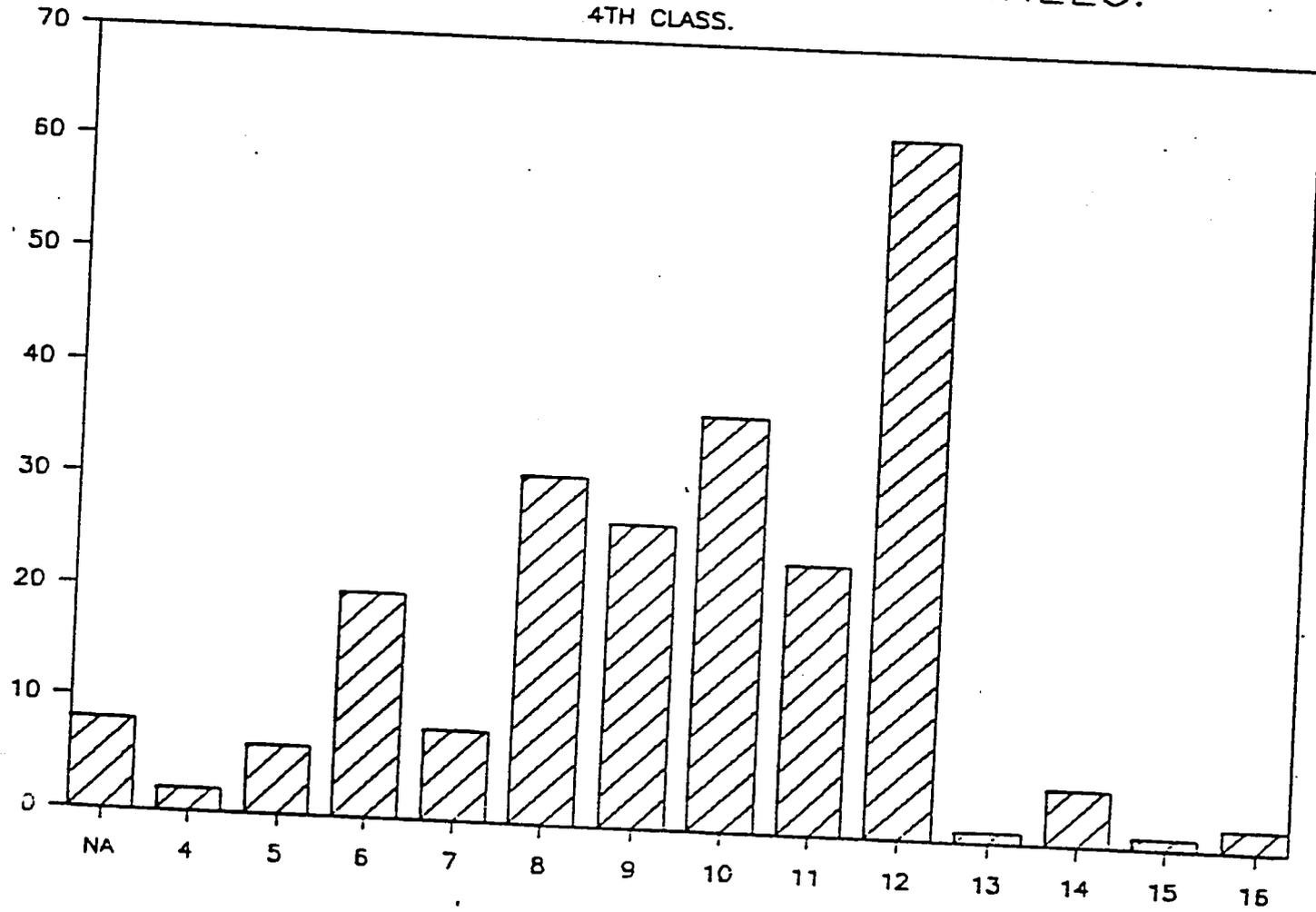
# Age Distribution and Comparison.

N=813

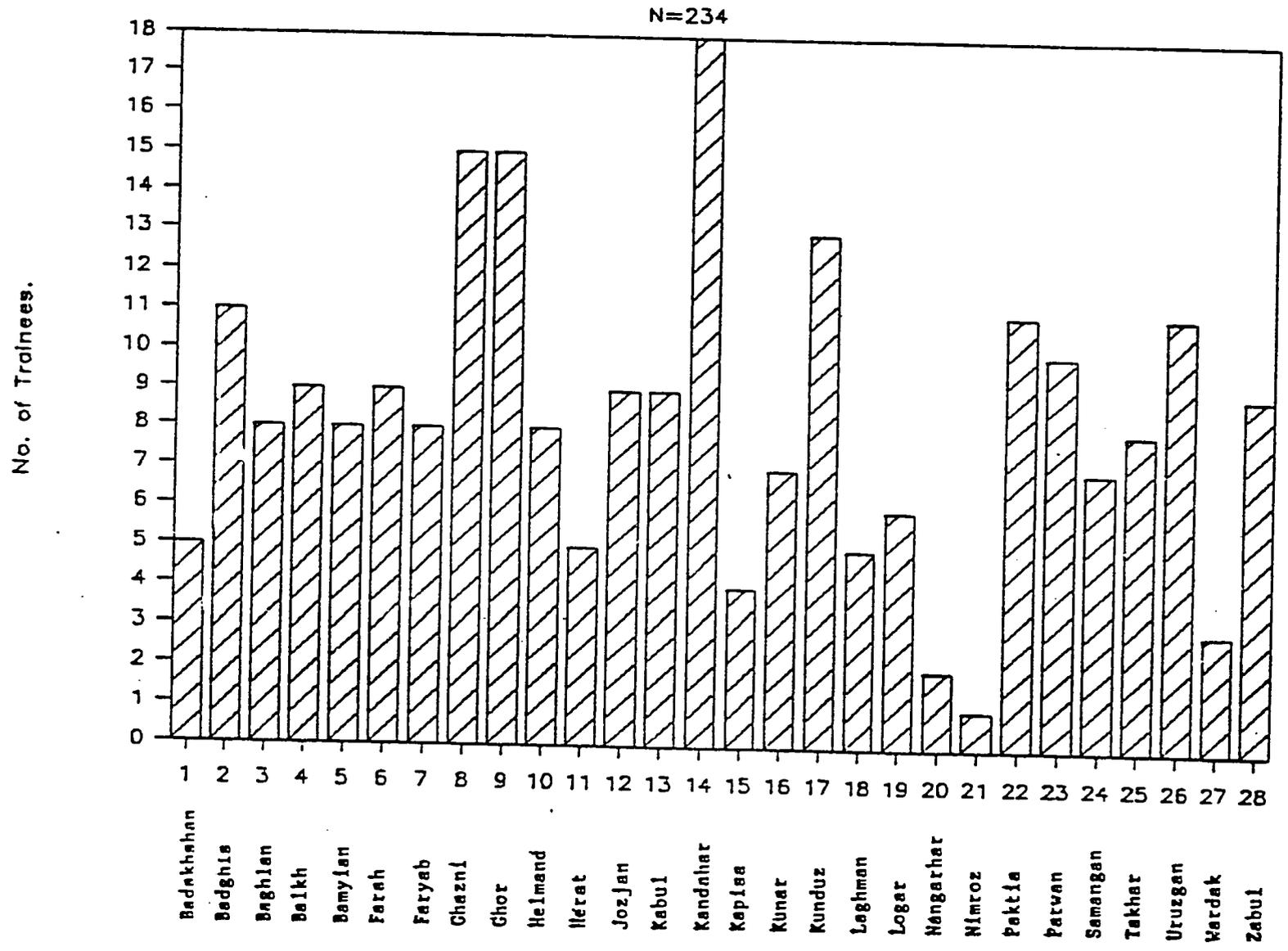


# EDUCATIONAL LEVEL OF TRAINEES.

4TH CLASS.

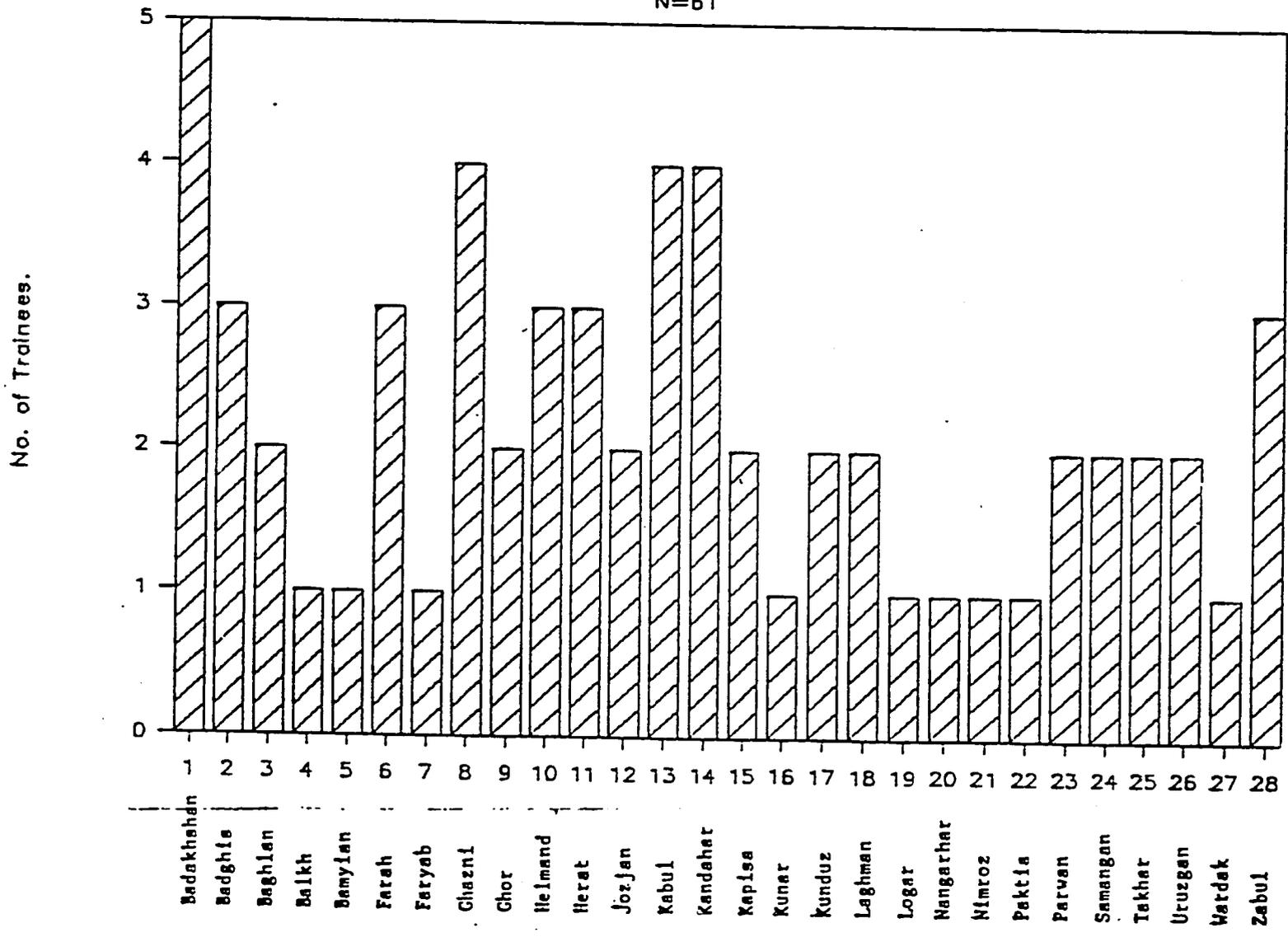


### 4th Class – Provincial Distribution.



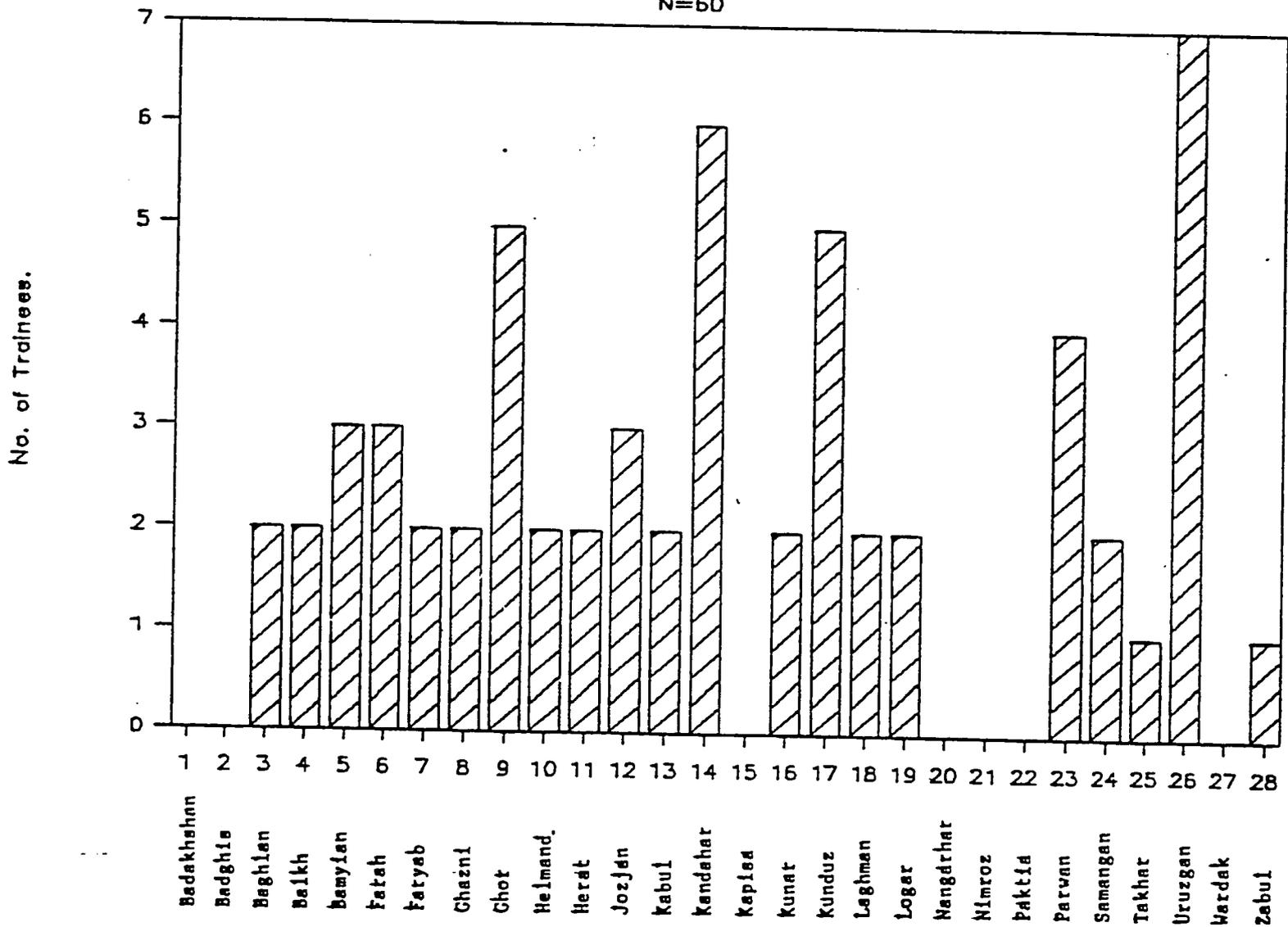
# JAMIAT 4th Class – Provincial Dist.

N=61



# ANLF 4th Class—Provincial Distribution.

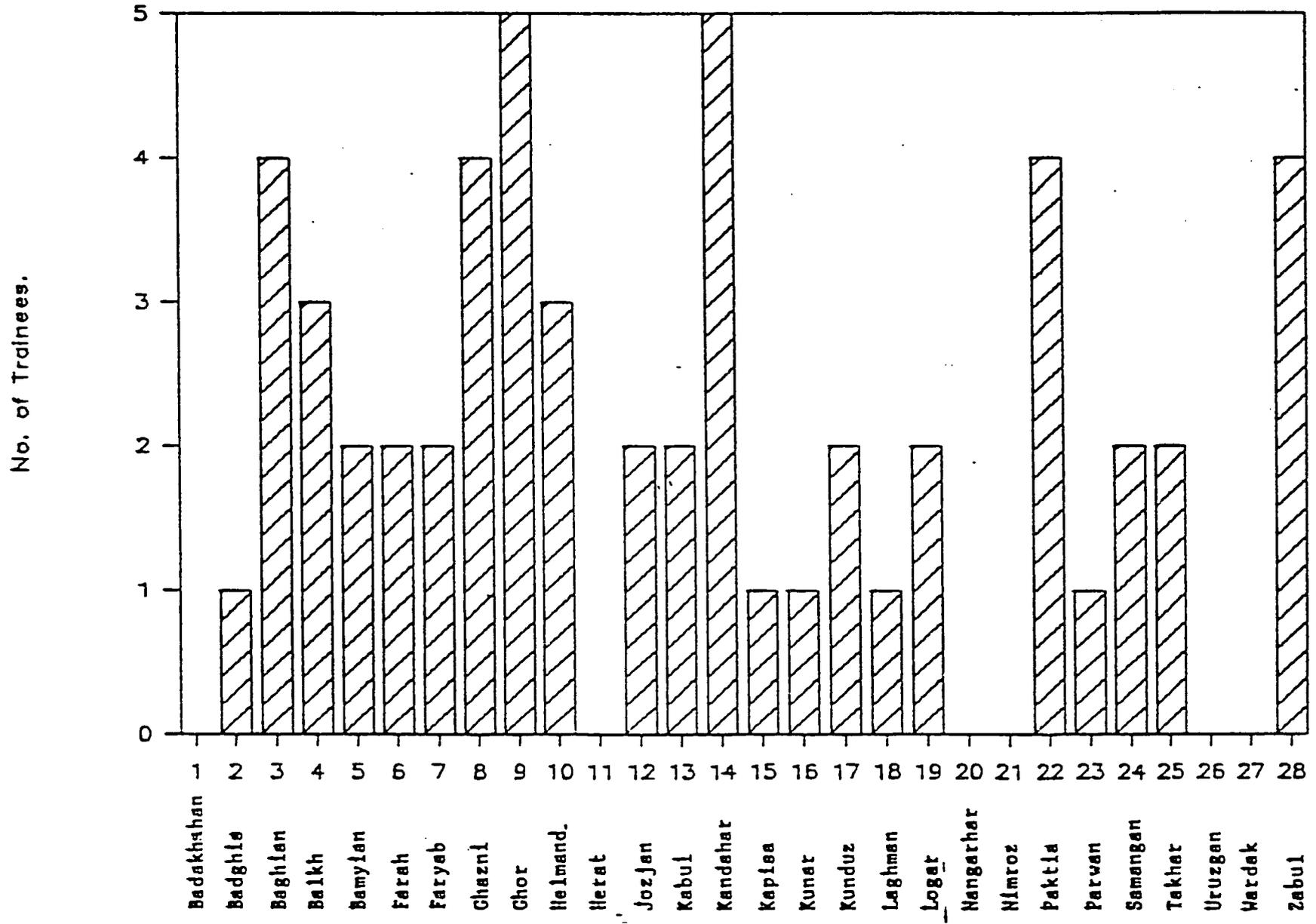
N=60



# HARAKAT 4th Class. Provincial Dist.

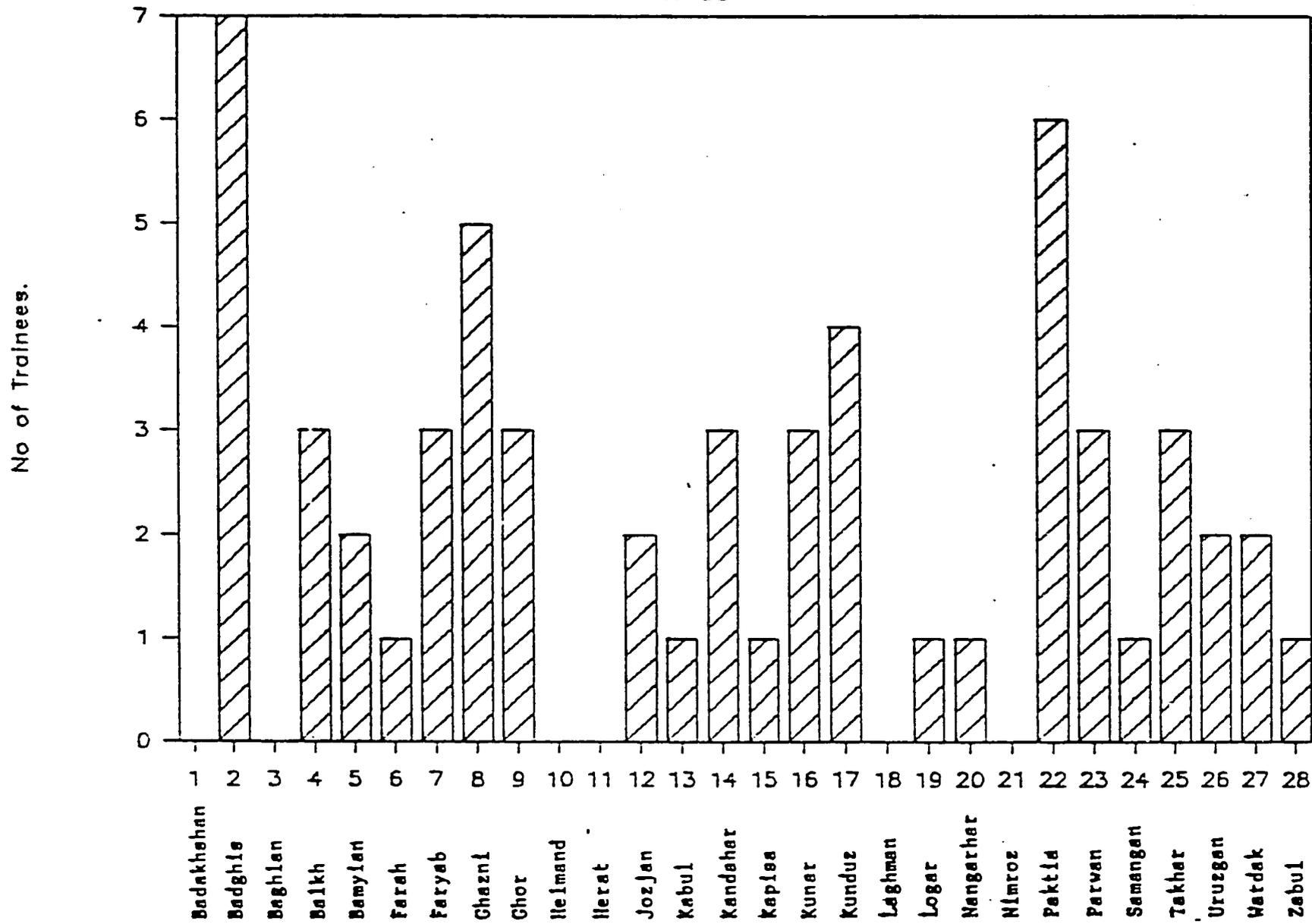
34

N=55



# MAHAZ 4th Class – Provincial Dist.

N=58



Province Frequency					
Bin Range Values	A.M.L.F HARAKAT	JANIAT	MAHAZ	Total	
1 Badakhshan	0		5		5
2 Badghis	0	1	3	7	11
3 Baghlan	2	4	2		8
4 Balkh	2	3	1	3	9
5 Bamiyan	3	2	1	2	8
6 Farah	3	2	3	1	9
7 Faryab	2	2	1	3	8
8 Ghazni	2	4	4	5	15
9 Ghor	5	5	2	3	15
10 Helmand	2	3	3		8
11 Herat	2		3		5
12 Jozjan	3	2	2	2	9
13 Kabul	2	2	4	1	9
14 Kandahar	6	5	4	3	18
15 Kapisa	0	1	2	1	4
16 Kunar	2	1	1	3	7
17 Kunduz	5	2	2	4	13
18 Laghman	2	1	2		5
19 Logar	2	2	1	1	6
20 Mangarhar			1	1	2
21 Niaroz			1		1
22 Paktia		4	1	6	11
23 Parwan	4	1	2	3	10
24 Samangan	2	2	2	1	7
25 Takhar	1	2	2	3	8
26 Uruzgan	7		2	2	11
27 Wardak			1	2	3
28 Zabul	1	4	3	1	9
	60	55	61	58	234

Note these figures correspond to 4th BHM Class, April 1988.

Serial	DISTRICT	PROVINCE	ANLF	HARAKAT	JAMIAT	MAHAZ	Total
1	0000	HERAT	1			1	2
2	0000	HERAT				1	1
3	AGCHA	JOZJAN				1	1
4	ALI ABAD	KUNDOZ	1				1
5	ALI SHANG	LAGHMAN	2			1	3
6	ALINGAR	LAGHMAN		1			1
7	AMAN SAHIB	FUNDOZ	1	1		2	4
8	ANAR DARA	HELMAND				1	1
9	ANDAR	GHAZNI				1	1
10	ANDARAB	BAGHLAN		2			2
11	ARGHANDAP	KANDAHAR	2			3	5
12	ARGHANDAP	ZARUL	1			1	2
13	ARGHISTAN	KANDAHAR	1				1
14	ASMAR	KUNAR				1	1
15	AZRA	LOGAR	2				2
16	BABASAHIB	KANDAHAR		1			1
18	BAGRAM	PARWAN				1	1
19	BAGRAMI	ZABUL	2			1	3
20	BAHRAK	BADAKHSHAN				1	1
21	BALA PULOX	FARAH		2			2
22	BALKH	BALKH	2			1	3
23	BARAKI BARAK	LOGAR		2		1	3
24	CENTER	ZABUL				2	2
25	CENTER	FUNDOZ	1			1	2
26	CENTER	BADGHIS				1	1
27	CENTER	LOGAR				1	1
28	CENTER	FARAH	3			1	4
29	CENTER	SAMANGAN		1		1	2
30	CENTER	GHAZNI		1		2	3
31	CENTER	TAKHAR		1		2	3
32	CENTER	JOZJAN		1		1	2
33	CENTER	URUZGAN				1	1
34	CENTER	KANDAHAR				1	1
35	CENTER	WARDAK				1	1
36	CENTER	RAMYIAN				1	1
37	CENTER	KUNAR	1				1
38	CENTER	BADAKHSHAN				2	2
39	CENTER	HELMAND		1			1
40	CENTER	FARYAB	1			1	2
41	CHAGHCHARAN	GHOR	1				1
42	CHAKHANSUR	NIMROZ				1	1
43	CHAMKANI	PAKTTA		1		1	2
44	CHANTAL	BALKH		1			1
45	CHAR BOLAK	BALKH				2	2
46	CHAR DARA	KUNDOZ		1		1	2
47	CHARDEHI	ZABUL		2			2
48	CHASHTI SHARIF	HERAT				1	1
49	CHAWKI	KUNAR				1	1
51	CHORBAHD	PARWAN	3				3
52	DAI CHUPAN	ZABUL		2		2	4
53	DAND	KANDAHAR	1	1		1	3
54	DARAI SUF	SAMANGAN	1			1	2
55	DEHRAWAD	URUZGAN				1	1
56	DERWAZ	BADAKHSHAN				1	1
57	DOSHI	BAGHLAN				2	2
58	DOWLAT ABAD	FARYAB		1			1
59	FARKHAR	TAKHAR		1			1

27

Serial	DISTRICT	PROVINCE	ANLF	HARAKAT	JAMIAT	MAHAZ	Total
60	GHORBAND	PARVAN	3	1			4
61	GHORMACH	BADGHIS				1	1
62	SOMAL	PAKTIA				1	1
63	GUZARA	HERAT	1		1		2
64	IMAM SAHIB	KUNDUZ	1	1		2	4
65	ISHKAMESH	TAKHAR				1	1
66	JAGHATO	GHAZNI	1		1		2
67	JASHORI	GHAZNI	1				1
68	JALBAK	ZABUL		1			1
69	JAWAND	BADGHIS		1		1	2
70	KACHRAN	URUZGAN	1				1
71	KAHKARO	BANYIAN	1				1
72	KHAKREZ	KANDAHAR	1			1	2
73	KHAN ABAD	KUNDUZ	2		1	1	4
74	KHAS URUZGAN	URUZGAN	2		1		3
75	KHAWAJA GHAR	TAKHAR	1				1
76	KHEER KOT	PAKTIA				2	2
77	KHUST FARANG	BAGHLAN		1	1		2
78	KHULM	SAMANGAN	1				1
79	KHUST	PAKTIA		1			1
80	KISEM	BADAKHSHAN			1		1
81	KOHISTAN	KAPISA		1			1
82	KOST FARANG	BAGHLAN		0			0
83	LALE SARJANGLE	GHOR	2				2
84	MAIWAND	KANDAHAR		2		1	3
85	MARUF	KANDAHAR		1			1
86	MOGOR	GHAZNI		3		1	4
87	MUSA QALA	HELMAND	2	1			3
88	MADE ALI	HELMAND			2		2
89	MAHREEM	BAGHLAN	1		1		2
90	MAHRI SHAHI	BALKH		1			1
91	PAGHMAN	KAPUL				1	1
92	PANJWAI	KANDAHAR	1				1
93	PASHTON KOT	FARYAB	1	1		1	3
94	PASSA BAND	GHOR		1	1	2	4
95	PEACH	KUNAR	1			1	2
96	PUL-I-KHUMRI	BAGHLAN	1	1		1	3
97	PUNJ SHER	KAPISA			1		1
98	PURCHMAN	FARAH				1	1
99	BADES	BADGHIS			2	2	4
100	DARABAGH	GHAZNI			2	1	3
102	BARGHAI	LAGHMAN			1		1
103	DAYSAR	FARYAB				2	2
104	RODAT	NANGARHAR			1		1
105	ROWEDDAB	SAMANGAN		1			1
106	SAD KARAM	PAKTIA		1	1	0	2
107	SAIGHAN	BANYIAN	2	2		1	5
108	SANG CHARAK	JOZJAN	1				1
109	SANGEEN	HELMAND		1			1
110	SARI PUL	JOZJAN	2	1	1	1	5
111	SARKANOD	KUNAR		1			1
112	SHAH ZOY	ZABUL		1			1
113	SHAHRAK	GHOR		2		1	3
114	SHAHRISTAN	URUZGAN				1	1
115	SHALGERA	BALKH					1
116	SHARARA	ZABUL					1
117	SHIN DAND	FARAH					2

Serial	DISTRICT	PROVINCE	ANLF	HARAKAT	JAMIAH	MAHAZ	Total
118	SORKHI FARSA	FARWAN	1		2	2	5
119	SYED ABAD	WARDAK				1	1
120	TAGAB	PARISA			1	1	2
121	TAHT	PAKTIYA		1			1
122	TEVARA	GHOR	2	1	1		4
123	TULAK	GHOR		1			1
124	URGON	PAKTIYA				1	1
125	WARAS	PANYIAN				1	1
			60	55	61	58	234

ANNEX TWO

Proposal for Establishing a Regional Training Center

A PROPOSAL FOR  
ESTABLISHING A REGIONAL TRAINING CENTER IN TAKHAR PROVINCE  
AFGHANISTAN

**INTRODUCTION**

Over the past several years the "Resistance", under the leadership of Commander Masood, has slowly developed an organization or administrative setup (Supervisory Council) to focus on civil matters in several of Afghanistan's northern provinces. Within this administrative setup health has been given a priority, as evidenced by the appointment of a Regional Medical Officer, Dr. Sahar, establishing and running a 20 bed provincial hospital (Takhar Central) plus a 10 bed hospital in Takhar and a 10 bed hospital in Baghlan as well as 14 clinics spread throughout 4 provinces. It should be noted, however, that some of the facilities listed above are sponsored by private voluntary organizations.

A proposal was received through Dr. Sahar's representative in Peshawar, Dr. Wasiq, requesting financial and technical support for establishing a Training Center at the Takhar Provincial Hospital.

As this is one of the few administratively well organized areas in Afghanistan, this is an excellent opportunity for expanding health services through local leadership. The benefits of such an approach are obvious, however, some of the positive factors are:

1. ability to respond quickly to local health needs, particularly important with the anticipated return of refugees;
2. improved trainee selection process and post training follow-up (this unfortunately is lacking in Peshawar based training);
3. training tailored for managing specific health problems in the area,
4. strengthening team working relationships and referral system and;
5. improved control and distribution of medical supplies.

## THE PROPOSAL

It is proposed that MSH directly support the Supervisory Council's request for establishing and operating a Regional Training Center attached to the Takhar Provincial Hospital in Afghanistan.

### I. THE TRAINING CENTER OBJECTIVES

The objectives are to:

1. carry out Basic Health Worker training;
2. conduct Refresher Training for Basic Health Workers
3. carry out Basic Health Worker training for women.

Discussions have been held at the AHC Training Center with Dr. Wasiq and Dr. Fatimie. Dr. Wasiq agrees that:

1. the AHC Basic Health Worker curriculum and training plan should be followed;
2. training materials should be the same as used by the Training Center;
3. testing and certification should be coordinated with the AHC Training Center;
4. close technical links should be maintained between the Regional Training Center and the AHC Training Center.

Dr. Fatimie stated that he was prepared, within his capacity, to provide technical support for the Takhar Training Center. It is important that such a technical link be established and maintained. There are currently so many different categories of health care providers, it is not advisable to encourage or even support yet another level worker. Further, with standardization and Alliance recognition, there will hopefully be a place for these workers in the new health care delivery system. Basic Health Workers, can be an extremely valuable resource for quickly implementing rural primary health care services.

With regard to BHW refresher training, this type training can best be carried out in small groups near the Basic Health Worker's work station. One of the high priority areas for such training is maternal and child health, as this topic was inadequately covered in the Peshawar based training programs due to lack of access to clinics/homes for MCH training.

Objective 3 listed above, Female Basic Health Workers. An operational plan needs to be developed, however, it was agreed that services for women and children are inadequate and need to be developed in a culturally acceptable way as quickly as possible. This is extremely important in view of the anticipated return of millions of refugees, who have generally had access to health care services.

Gradually, as the training program is developed, recruitment of trainees for Peshawar based BHW training should be discontinued.

## II. THE SERVICE AREA

According to information provided, the Takhar Provincial Hospital is the main referral hospital for Takhar, Baglan, Kunduz and Badakshan provinces. Pre-war population was around 2.8 million. Exact figures for the present are not known, however, it has been reported that a large percentage of the population remained and for planning purposes it should be assumed that the majority of refugees will be returning to their home provinces.

## III. THE HOSPITAL

The hospital altogether has 20 beds, (10 surgical and 10 medical) plus the following services: operating room, x-ray, laboratory, orthopedic center, dental clinic, outpatient room. The breakdown of the hospital staff is as follows:

Doctors.....	3
Medical Technicians.....	3
X-ray technician.....	2
Laboratory technician.....	2
Orthopedic center technicians.....	2
Dental technicians.....	2
Basic Health Workers.....	4
Field Practitioners.....	1
Support staff.....	<u>9</u>
Total	28

IV. THE PLAN OF ACTION

It is strongly recommended that a full time training staff be assigned to the Provincial Training Center. Less than full time staff is risking the quality of training, as well as the potential of the trainee. Dr. Wasiq is of the opinion that staff can be recruited from Peshawar to move back into Afghanistan.

**BASIC HEALTH WORKER TRAINING**

Number of three month training cycles per year: 3

Number of trainees per class; 25

Training Staff: Doctors.....2

Nurses.....2

Admin. Assistant.....1

Watchman.....1

If trainers are recruited in Peshawar, it is recommended that the trainer (s) immediately be assigned to the AHC Training Center for orientation and to participate in the present BHW Training program at Jamiat Camp, Dara.

During this orientation period, supplies/equipment, which cannot be obtained inside, will be procured and prepared for shipment to Takhar hopefully late June or early July. Also during this orientation a working relationship between THE AHC Training Center and the Regional Training Center can be established.

Drafted by: R. Johnson  
27 April 1988

ANNEX THREE

List of Training Materials for the Regional Training Center

MANAGEMENT SCIENCES FOR HEALTH  
PESHAWAR

9 June 1988

TO: Dr. Wasiq

From: Dick Johnson

Subject: Training Materials for the Takhar Training Center

The following list of training materials have been obtained for the Takhar Training Center. These materials have been sent to the MSH Warehouse to be specially packed for transport by animal to Takhar. The packed items will be weighed to determine the cost for transportation via Chitral i.e. Afs 5,700 per seer. It is expected that this packing process will be completed by 20 June. Please advise MSH when you are ready to have the consignment sent to Chitral for onward shipment to Takhar.

BOOKS

01. Where There Is No Doctor, David Werner, 1977.
02. Disabled Village Children, David Werner, 1987.
03. Where There Is No Dentist, Murray Dickson, 1983.
04. Teaching Health-Care Workers, A Practical Guide  
Fred Abbatt, Rosemary McMahon, 1987.
05. Primary Anaesthesia, Maurice King, 1988.....2 copies
06. Primary Surgery, Vol. 2, Trauma, Maurice King, 1987,..2 copies
07. Conn's Current Therapy, Rakel, 1988.
08. Primary Child Care, Book One, Maurice King, Reprinted 86
09. Primary Child Care, Book 2, King, Reprinted 86.
10. First Aid For Community Health Workers, Skeet, 1984.
11. Practical Care of Sick Children, Dean, 1986.
12. Nutrition Handbook for Community Workers in the Tropics,  
MacMillan/CFNI, 1986.
13. Manual on Feeding Infants and Young Children, Cameron and  
Hofvander, 1983.
14. Breast-feeding in Practice - A manual for health workers,  
Helsing with King, 1982.
15. Helping Mothers to Breast Feed, King, 1985.

16. Guidelines to Drug Usage, Upunda, Yudkin, Brown, 1983.
17. Better Child Care, Voluntary Health Assoc. of India, 1977.
18. Primary Health Education, Yound and Durston, 1987.
19. Obstetric Emergencies - A Manual for Rural Health Workers, Everett, 1987.
20. A Practical Guide to the Diagnosis and Treatment of Leprosy in the Basic Health Unit, Third Edition, 1985.
21. Mental Health, Swift, Reprinted 1985.
22. Eye Diseases in Hot Climates, Sandfor-Smith, 1986.
23. Sanitation Without Water, Winblad and Kilama, 1986.
24. Simple Aids for Daily Living, AHRTAG, 1987.
25. Essential Action to Minimise Disability in Leprosy Patients, Watson, 1986.
26. A Practical Guide to the Basic Treatment of War Injuries, Gardmer, 1987.
27. Where There is No Dentist, Dari Edition.
28. Managing Drug Supply, MSH, 1982.
29. Current Pediatric Diagnosis & Treatment, Lang, 1987.
30. Taber's Cyclopedic Medical Dictionary, 15th. Edition
31. Dorland's Medical, English to Persian Dictionary 1987.
32. English Persian Dictionary, Kashani, 1987
33. Handbook of Clinical Pharmacology, Saebi, 86. Farsi.
34. Persian-English Dictionary
35. Farquharsons's Textbook of Operative Surgery, 1987.
36. Current Medical Diagnosis & Treatment, 1988.
37. Cecil Essentials of Medicine, 1986.
38. Basic and Clinical Pharmacology, Katzung, 1987.
39. Obstetrics, ELBS, Clayton, 14th Edition, 1985.
40. Gynaecology, ELBS, Clayton, 14 Edition, 1985.

Materials from AHC Training Center

- |     |  |           |
|-----|--|-----------|
| 01. | Field Manual 1, Standard Drug Formulary (For Doctors & Nurses) DARI-ENGLISH..... | 5 copies. |
| 02  | How TB Spreads - Dari.....   | 5 copies  |
| 03. | How Harmful Organisms Are Spread - Dari.....                                     | 5 copies  |
| 04. | Health Care - Dari.....  | 5 copies  |
| 05. | Right and Wrong Use of Modern Medicines.....                                     | 5 copies  |

Slide Sets Produced by TALC

- |     |  |
|-----|--|
| 01. | Management of Cough in Asian Children      |
| 02. | Immunization Clinical Signs                |
| 03. | Development in the First Year              |
| 04  | Diarrhoea Management                       |
| 05. | Common Oral Diseases                       |
| 06. | Chronic Periodontal Disease                |
| 07. | Primary Eye Care                           |
| 08. | Malnutrition in India                      |
| 09. | Severe Measles                             |
| 10. | Protein Calorie Deficiency                 |
| 11. | Schools a Resource for Primary Health Care |
| 12. | Weaning Foods and Energy                   |

**EQUIPMENT**

01. Slide Projector, 35 mm, Voigtlander, VP 300A.....1

02. Slide Trays.....4

03. Olympia Type Writer, English set.....1

04. Mini Torso.....1

05. Skeleton, miniature.....1

06. Anatomical Charts, Set of 8.....1

07. Type Writer Ribbons.....4

4

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ANNEX FOUR

Progress Report Form for the Regional Training Center

REGIONAL TRAINING CENTER  
TAKHAR PROVINCIAL HOSPITAL

PROGRESS REPORT

TRAINING CENTER:

1. Description of Activities
  - a. Major accomplishments
  - b. List of Trainers, qualifications and date of appointment
  - c. Problems
  - d. Women's activities (Mother & Child Health)
  - e. Future plans
  - f. Photo graphs of activities, facilities, etc., if possible.
2. Development of Training Center (Report only until facility completed)
  - a. Classroom & Office Building
    1. Date Construction started: \_\_\_\_\_
    2. Date Construction completed: \_\_\_\_\_
    3. Attach simple line drawing of building
  - b. Hostel Building
    1. Date Construction started: \_\_\_\_\_
    2. Date Construction completed: \_\_\_\_\_
    3. Attach simple line drawing of building.

BASIC HEALTH WORKER TRAINING

1. Date BHW training course started: \_\_\_\_\_
2. Date BHW training course completed: \_\_\_\_\_
3. Number of BHW trainees starting: \_\_\_\_\_
4. Number of BHW trainees completing course and certified as competent BHWs \_\_\_\_\_
5. BHW Biodata (See Attached Form)
6. List of BHWs and assigned place of work

BASIC HEALTH WORKER TRAINING PROGRAM

INFORMATION SHEET

NAME OF TRAINING CENTER \_\_\_\_\_

NAME: \_\_\_\_\_ AGE: \_\_\_\_\_

FATHER'S NAME \_\_\_\_\_

VILLAGE \_\_\_\_\_ DISTRICT \_\_\_\_\_ PROVINCE \_\_\_\_\_

LANGUAGE (S)

SPOKEN AT HOME \_\_\_\_\_

OTHER: 1 \_\_\_\_\_ 2. \_\_\_\_\_

EDUCATION LEVEL \_\_\_\_\_

GENERAL COMMANDER NAME: \_\_\_\_\_

LOCAL COMMANDER NAME: \_\_\_\_\_

WORK ASSIGNMENT LOCATION

1. PROVINCE \_\_\_\_\_

2. DISTRICT \_\_\_\_\_

3. VILLAGE \_\_\_\_\_

LOCATION OF FAMILY ADDRESS: \_\_\_\_\_

DATE TRAINING STARTED \_\_\_\_\_

DATE TRAINING COMPLETED \_\_\_\_\_

FINAL TEST SCORE:

WRITTEN \_\_\_\_\_

ORAL \_\_\_\_\_

PRACTICAL \_\_\_\_\_

\_\_\_\_\_  
TRAINEE'S SIGNATURE

CERTIFIED BY \_\_\_\_\_

DATE \_\_\_\_\_

ANNEX FIVE

Recommendations for Selection of BHWs

RECOMMENDATIONS ABOUT THE SELECTION OF THE BHWS.

Peshawar, March 14th, 1988

From: Dr. Lawrence Laumonier

To: AHC High Council.

Subject: schedule recommended for the selection operation of the BHWS and departure operation.

1. MONTH 1:

During the 2 first weeks of month 1 (just after the beginning of the new session):

a. The MSII and AHC technical staff recommend to the AHC High Council the selection of the provinces to be chosen for the next session. The High Council decides.

b. The Health Committees get informations from their own Logistic Committee about the commanders who should be chosen in these provinces.

c. Each Health Committee sends an OFFICIAL AHC LETTER to those commanders, requesting them to select, from the area, X candidates and to send them for the date of pre-test.

This letter should be proposed jointly by the medical sub-committee and the clinic Department to the AHC High Council who will decide. The letter should include the criterias for selection (education level, family remaining inside, location recommended regarding the model of the clinics...) and explains the procedure of the pre-test.

2. MONTH 2:

The messengers are delivering this letter to the commanders inside Afghanistan. The commanders, who are staying far away, have time to do a quiet selection of candidates, and send them to Peshawar for the right pre-test date, WITH A LETTER OF INTRODUCTION EXPLAINING THE EXACT PLACE OF WORK THEY PROPOSE, AND THE NAME OF THE COMMANDER WHO WILL HAVE THE RESPONSABILITY OF SUPERVISION INSIDE.

3. MONTH 3:

a. 2 weeks before the pre-test date, the Health Committees have time to see the candidates who arrived from inside, and give them a letter of introduction for the Training Center with a photograph of the candidate on it. This letter will include THE EXACT PLACE OF ASSIGNEMENT (province, district, village or markaz) AND THE EXACT NAME OF THE COMMANDER WHO WILL HAVE THE RESPONSABILITY OF SUPERVISION.

the training center has time to see the candidates, sent by the Health Committees, and establishes the list of candidates and prepares the forms for the pre-test examination for each candidates with their photography.

#### 4. PRE-TEST PERIOD:

1. The Training Center establishes the list of the 240 candidates who have successfully passed the examination. The Training center send this list to the Supply Department, WITH THE LETTER OF ASSIGNMENT PROVIDED BY THE HEALTH COMMITTEE.

2. When the candidates go to the Training center to see the results, they are asked to go to the AMC SUPPLY DEPARTMENT TO BE REGISTERED OFFICIALLY: the new BHW have to bring 2 photographs.

#### 5. TRAINING SESSION PERIOD:

15 days before the graduation of the BHWs, Eng. Najib from the Supply department, goes to each training camp to ask to the BHWs their EXACT point of entry on the border for their departure: the BHWs will not be allowed to change this point of entry after all.

#### 6. GRADUATION TIME:

1. The date of the graduation will be fixed AFTER THE FINAL RESULTS OF ALL THE BHWs provided by the Training center.

2. The Training center will provide this list to the Supply Department at the same time.

ANNEX SIX

Distribution of Clinics Based on Population Density

MANAGEMENT SCIENCES FOR HEALTH  
PESHAWAR

ANALYSIS OF PROVINCIAL DISTRIBUTION OF CLINICS  
NEEDED INSIDE AFGHANISTAN, BASED ON RATE OF POPULATION.

From: Dr Laurence Laumonier, MSH Medical and Field Operation Advisor.  
with the collaboration of Dr Paul Ickx, MSH Medical Associate.

To: MSH/AHC/CMC

Subject: Some explanations about the analysis of provincial distribution of clinics needed inside Afghanistan, based on rate of population.

A. RATE OF PROVINCIAL POPULATION:

The following analysis has to be divided in 2 parts:

A. the first one is based on the actual estimated population inside Afghanistan excluding the refugee population in Iran and Pakistan. The rate of population is provided from 2 different sources; one is based on the pre-war population (1979) minus the official number of refugees provided by UNHCR; the second one is based on a demographic analysis done in 1985, using different sources of information and taking into account differentiated migration trends for several provinces, due to the war situation in the country. The rates provided by these 2 sources were enough reasonably comparable to be combined together and divided by 2.

2 restrictions should be retained in those features:  
- the number of the refugees of Herat province in Iran, provided by UNHCR seems to be too high (91%);  
- the number of refugees of Logar province provided by UNHCR is obviously over-estimated (109%)

These 2 restrictions show that these features must be very carefully used. (In fact, the Chief commander of Herat province, Ismael Khan, claims through his own administration that 25% of the pre-war population of Herat province has gone to Iran as refugees, 40% else has been displaced in the Herat province itself, and 35% are still at the same place than before the war).

B. the second part of the analysis is based on the pre-war population rate registered in 1979. (including, then, all the actual refugees).

So, the 2 parts of the study allow to feagure out how many clinics are needed to implement in each province during the actual situation , and will be needed to implement in each province when the refugees will have returned to Afghanistan.

Despite of Public Health Standarts, regarding the actual low level of medical development of Afghanistan, the coverage of population has been estimated for 15,000 persons and for 30,000 persons.

D. DEFINITION OF ONE CLINIC:

1. CLINICS IMFLEMENTED BY AHC:

The implementation of one AHC clinic is based on a standardized medical staff i.e 2 diploma nurses or the equivalent (= 3 "medical technicians"). One clinic do not have in-patients beds.

2. CLINICS IMPLEMENTED BY CMC:

By the name of "clinic", is included:

- or 1 doctor, only
- or 1 medical technician of 16 months (MTA) OR  
1 M.C.I clinic
- or 3 medical technicians of I.M.C or/and Freedom Medicine.

## ESTIMATES OF ACTUAL POPULATION

Record#	name	popunhr	pop1	popaverage
1		0	0	0
2	PAKTIKA	-19600	56169	18284
3	MINIROZ	4056	61894	32975
4	LOGAR	-23220	108743	42862
5	LUNAR	72900	65101	68000
6	FARAF	32250	140151	86200
7	DANDAHAR	102060	91184	96622
8	LAGIHAN	34210	172040	103125
9	HERAT	69210	140880	105045
10	LAPISA	103800	122633	113216
11	ZABUL	130133	107090	118612
12	PARFIA	149400	120548	134974
13	DABGHIS	191178	129096	158137
14	WARDAK	280041	87467	183754
15	SAHAHGAN	298531	156393	207462
16	DAHMAN	255550	160310	207930
17	PARWAN	357110	132986	245048
18	GHOR	295074	201752	248413
19	DAGHILAN	390260	126816	258538
20	GHAZNI	308200	217715	302958
21	LUNDUZ	482850	169002	323926
22	URUZGAN	393384	265150	329267
23	HELHANI	383320	309123	346222
24	BADAKHSHAN	473100	283694	378397
25	HANDAKHAR	350620	419936	385278
26	PARJAB	466400	323648	395024
27	TAKHAR	515320	275849	395584
28	DALHIZ	556482	349432	452957
29	JUZJAN	582521	376128	479324
30	FARAF	1250412	2780963	2015688

Version 2/23 April 1998

AFGHAN REFUGEE PROVINCES OF ORIGIN

Province	Pre-war Population <sup>(1)</sup> (all figures x 1000)	Area of Asylum				Total	Total as % All Refugees	Total as % Province Population
		Pakistan <sup>(2)</sup>			Iran <sup>(3)</sup>			
		MFFP	Baluchistan	Punjab				
Herat	757				700	700	15.25	91.9
Kandahar	567	1	463	2		466	10.01	83.1
Niangrahar	796	387		10		399	7.26	53.0
Kabul	847	264	96			360	9.35	49.8
Kapisa	479	314	16	19		349	8.10	79.0
Kapisa	258	262	21			283	6.57	100.0
Kapisa	255	266		2		268	6.22	100.0
Kapisa	211	223		1		224	5.20	89.2
Kunar	250	223				223	5.19	71.7
Kandahar	235				200	200	4.84	85.1
Kandahar	518		135		20	155	3.60	26.0
Kandahar	104		17		100	117	2.72	76.1
Kandahar	474	52	(5)	47		104	2.41	21.0
Kandahar	555	30	(5)	41		76	1.76	13.6
Kandahar	1,319	55		13		59	1.50	5.2
Kandahar	444		11		(40)	51	1.19	11.4
Kandahar	410	48		5		53	1.23	12.9
Kandahar	177	1	48			49	1.14	27.3
Kandahar	231		(3)		(40)	(43)	1.00	19.3
Kandahar	328		(3)		(40)	43	1.00	12.7
Kandahar	459	28				28	0.65	5.4
Kandahar	567	2	5	2		12	1.32	2.2
Kandahar	273	4	5	6		15	0.35	5.4
Kandahar	287		9			9	0.21	2.1
Kandahar	587			7		7	0.15	1.1
Kandahar	920		5			5	0.12	.9
Kandahar	269					NA		
Kandahar	583					NA		
Kandahar	345					NA		
Total	12,756	2163	847	157	1140	4305		

Source: (1) Census of Afghanistan (1979)

(2) UNHCR Sub-Offices Peshawar (2/88) Quetta (1/88) and Lahore (12/87)/based on SOP figures of registered refugees

(3) Estimates provided by VITA, Peshawar

All figures in % represent projections from aggregated estimates 2 & 3 above.

MANAGEMENT SCHEMES FOR HEALTH SERVICES  
Report on number of AMC and LMC clinics by province  
inside Afghanistan on one clinic per 1,000 of the PRC-UN  
population for planning purposes.

Province	No. of Clinics Implemented by AMC	No. of Clinics Implemented by LMC-centers.	No. of Clinics per 1000 pop. required to be implemented	No. of clinics planned for implementation by AMC
BAKAWA	1	25	7	2
BAKAWA	1	10	5	1
BAKAWA	1	21	5	3
BAKAWA	1	10	6	0
BAKAWA	1	1	6	0
BAKAWA	0	5	7	1
BAKAWA	2	3	11	0
BAKAWA	2	2	12	0
BAKAWA	1	10	12	1
BAKAWA	0	1	11	0
BAKAWA	1	3	11	0
BAKAWA	1	1	13	0
BAKAWA	0	0	16	0
BAKAWA	0	3	10	1
BAKAWA	1	0	10	1
BAKAWA	3	10	22	0
BAKAWA	1	11	23	1
BAKAWA	2	12	24	1
BAKAWA	1	5	24	1
BAKAWA	1	9	25	2
BAKAWA	1	6	26	0
BAKAWA	0	6	27	0
BAKAWA	1	5	29	0
BAKAWA	0	0	30	0
BAKAWA	2	6	31	1
BAKAWA	2	5	32	0
BAKAWA	1	12	33	2
BAKAWA	1	13	36	0
BAKAWA	1	16	7	0
BAKAWA	1			32
BAKAWA	11	250		

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MANAGEMENT SCIENCES / GA IQAI IHT/ESHAVAR  
Report on number of AMI and EIC clinics per province inside  
on one clinic per 50,000 of the PRC-DAR population basis  
for planning purposes.

Base of province	No. of Clinics Implemented by AMI	No. of Clinics Implemented by EIC-members.	No. of Clinics per 50000 pop. remaining to be implemented	No. of clinics planned for implementation by AMI
BAKRA	1	25	-16	7
BAHA	1	10	-13	1
BAJIA	1	21	-11	1
BAJIA	1	10	-3	3
BAJIA	1	10	1	1
BAJIA	1	10	1	0
BAJIA	0	3	1	0
BAJIA	0	1	2	0
BAJIA	2	3	3	0
BAJIA	1	1	3	0
BAJIA	2	2	1	1
BAJIA	2	1	3	1
BAJIA	0	11	3	0
BAJIA	1	0	3	1
BAJIA	1	12	3	1
BAJIA	2	3	3	0
BAJIA	1	3	7	0
BAJIA	0	7	7	1
BAJIA	1	0	0	0
BAJIA	0	8	9	7
BAJIA	1	5	9	1
BAJIA	1	12	10	0
BAJIA	0	6	11	0
BAJIA	0	0	11	0
BAJIA	0	6	11	2
BAJIA	2	5	11	0
BAJIA	1	13	11	7
BAJIA	1	5	13	1
BAJIA	2	16	27	0
BAJIA	1			
III Total III	11	750		32

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MANAGEMENT SCIENCES FOR HEALTH/PESHAWAR  
Report on number of AHC and CMC clinics by province  
inside Afghanistan on one clinic per 15,000 basis  
for planning purposes.

7

Name of province	No. of Clinics implemented by AHC	No. of Clinics implemented by CMC-members.	No. of Clinics per 15000 pop. remaining to be implemented	No. of clinics planned for implementation by AHC
LOGAR	4	10	-19	4
PAKTIA	4	24	-19	1
VARDAR	1	25	-14	2
HERAT	4	12	-9	0
DAMPRAHAR	2	12	-8	1
KUNAR	1	10	-6	3
KAPISA	1	10	-3	0
GIJAZI	3	10	-1	4
NIRROZI	0	1	1	0
PACTIYA	0	0	1	0
FARAH	2	2	2	1
KAPUR	0	5	3	0
LASHKAR	0	3	4	0
PARAKHIS	2	3	6	1
PARVAN	1	0	7	0
GHOR	4	1	9	2
PACTIA AN	1	6	10	1
PACTAN	0	4	10	0
SARANGAN	1	3	10	7
KANDAHAR	1	13	12	1
TAKHAR	1	9	16	1
URUGAN	1	5	16	0
IMLAKAND	1	5	17	1
PUNJAB	2	3	17	2
FARIAB	2	6	18	0
BAGLAMSHAN	0	6	19	0
JOZJAN	1	11	20	0
BALCH	0	0	22	0
KABUL	1	16	117	0
!!! Total !!!	41	250		32

MANAGEMENT SCIENCES FOR HEALTH/PESIAWAR  
 Report on number of AIC and CMC clinics per province inside  
 on one clinic per 30,000 basis  
 for planning purposes.

Name of province	No. of Clinics Implemented by AIC	No. of Clinics Implemented by CMC-members.	No. of Clinics per 30,000 pop. remaining to be implemented	No. of clinics planned for implementation by AIC
PAJAJARAN	1	24	-24	1
LOGAR	1	18	-21	4
WAGAY	1	25	-20	2
HERAT	1	17	-12	0
SHAHRI	3	18	-11	4
BANGSAWAN	2	17	-11	1
KUMAR	1	10	-9	3
LAFISA	1	10	-7	0
TARAH	2	2	-1	0
WANGSABIRAN	1	13	-1	7
TARUMAN	1	0	-1	1
TARUM	0	5	0	1
TARUM	2	3	0	0
PACIHIS	1	1	0	0
GIGIS	1	3	0	0
LAKSMA	0	1	0	0
KIRKOTI	0	0	1	0
PALINDI	0	6	2	2
PALINDI	1	4	3	1
PALINDI	0	1	3	0
PALINDI	1	3	3	1
SARANSAN	1	9	3	0
TAMBAR	1	11	4	2
JODJAN	1	6	5	1
TARJAN	2	6	5	1
TARJAN	1	5	6	0
URUJAN	1	5	6	1
URUJAN	1	5	6	1
URUJAN	7	3	7	0
URUJAN	0	6	7	0
PAPUNJAN	0	8	7	0
PALINDI	1	16	50	0
JABUL	1			32
!!! Total !!!	41	250		

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**ANNEX SEVEN**

**Monitoring Report from Kandahar Province**

MONITORING REPORT FROM  
KANDAHAR PROVINCE.

1 team of 2 persons went to survey 14 BHWs and 2 clinics in Kandahar province, during 1 1/2 months.

The conditions of war were not bad and the monitors could make their survey without problems.

1. BHWs:

code NO 0133: Gul Mohamad was present in the clinic and his commander also. He is working with Abdul Jalil (code NO 0139), who was absent because he had to transport wounded to Quetta at the time of the survey. The 2 BHWs were working with a third one (code NO 0134) who has been KILLED in February 1988 by bombardements. This clinic is underground; the population seems important and the supervision by the commander quite good. The 2 BHWs, working there, and their commander have introduced 3 other persons to be a part of the staff of an eventual clinic (ANLF);

code NO 0163: his commander, Abdul Hamid NIFA, has been in Peshawar since 3 months. the BHW has never come to the field (letter from the assistant of the commander, Mohd Aslam). The monitors asked for his name in the various districts and in Quetta and could not find him.

code NO. 0139: same commander, same problem: the population does not know him.

code NO 0309: the commander Abdul Bari ANLF, is no more present inside since 4 years; and the location is a narrow valley where nobody lives. (letter from commander of Mahaz, and population of Arghandab district).

code NO.0318: the commander Barwar ANLF, had left to Peshawar since 2 months. The BHW was not known as a "doctor" by anyone among the population. The monitors found him at home; he did not want to answer to their questions; he only said that his medicines were somewhere further; the monitors went there with the doctor Nadir (from ANLF) but could not find the medicines.

code No. 0299: same commander and same problem; nobody know his name. For these 2 BHWs, their absence has been certified by a letter signed by 5 or 6 commanders from the various Tanzeems.

code NO. 0314: the name of the BHW is not known by anyone; the commander Mughash (ANLF) has not been present since 4 months (he has gone to Peshawar);

code NO 0174, 0386, 0387: (Jamiat and ANLF); letter from the commander of NIFA Atta Mohamad (responsible for the 2 BHWs who are

working - see above) certifies that these 3 BHWs are not present. The monitors saw the NO. 0174 in an hotel in quetta; they try to take him with them at the begining of the survey but he escaped (no news of the medicines)

code No. 0445: the commander Fazludin NIFA was present and certified by letter that this BHE never came in the field for working.

code NO. 0444: NIFA; the name of the district, coming from the AHC/MSH list is not existing (certified by the Commander Atta Mohamad Ahmadi NIFA).

## 2. CLINIC:

- code NO. 1016:

NIFA  
district Maiwand; commander Abdul hamid (same kt than for code NO> 0163 and 0135).

the clinic does not exist and has not been found in the other districts visited.

- code NO. 1042:

ANLF  
district of Panjway.  
1 med. Techn 18 months  
2 med. tech. 12 months.

this clinic has gone with the monitors from Quetta. The clinic was newly established and working intensively.

ANNEX EIGHT

Job Description - Medical Supply Information/Procurement  
Officer

## JOB DESCRIPTION

TITLE : MEDICAL SUPPLY INFORMATION/PROCUREMENT OFFICER

REPORTS TO : ASSOCIATE MEDICAL ADVISOR

JOB SUMMARY : Responsible for assisting the Associate Medical Advisor with managing the MSH medical procurement.

### SPECIFIC RESPONSIBILITIES :

The incumbent is responsible for assisting the Associate Medical Advisor with :

1. obtaining and analyzing inventory data generated by the Warehouse regarding needed drugs and medical supplies in order to assure a continuous supply ;
2. monitoring the amount of supplies needed per time period, determining minimum/maximum stock levels of each item, monitoring lead time analysis of individual products, establishing economic order quantities for each product ;
3. maintaining liaison with AMEG regarding the status of medical supply orders i.e. expected date of delivery, changes in specifications, price control monitoring ;
4. advising Warehouse Manager to ensure good storage and repackaging practices, implementing sampling methods to ensure inventory quality control procedures ;
5. reviewing of interpretation of Greenbook clinical service data and providing advise regarding amount and type of drugs, various kits, suggesting cost effective therapy alternatives where needed ;
6. maintaining liaison with Training Advisor and Training Assistant/Medical Officer to ensure that medical supplies, equipment and drugs procured are coordinated with training programs ;
7. coordinating with consulting industrial pharmacists for monitoring of Good Manufacturing Practices and Good Laboratory Practices of manufacturers preselected for supply ;

8. preparing sample documents for procuring drugs, medical supplies and equipment, verifying office flow procedures relative to purchase orders and other requisition support documents ;
9. developing and updating generic lists of medical supplies for various health facilities inside Afghanistan
10. any other related duties assigned by Associate Medical Advisor.

**JOB REQUIREMENTS :**

1. Holder of Diploma in B.Sc. Honors Pharmacy or Master in Pharmacy.
2. Minimum three years professional experience.
3. Good working knowledge of English.
4. Working knowledge of computer use (dBase3plus, Lotus 123, Word Process) is desirable.

**POSITION ELEMENTS :**

- A. Supervision Received : Supervision over this position is exercised by the Associate Medical Advisor.
- B. Available Guidelines : Incumbent follows MSH policies and guidelines and uses technical references as required for carrying out job functions.
- C. Exercise of Judgement : Incumbent is required to exercise sound judgement in the performance of assigned technical duties and in his dealings with AMEG staff.
- D. Authority to make commitments : Incumbent has authority to decide on substitute products for outstanding orders.
- E. Nature, Level and Purpose of Contacts : Incumbent maintains contacts with MSH staff, and AMEG Medical Procurement Staff.
- F. Supervision exercised : none.
- G. Time Required to Perform Full Range of Duties : 3 months will be required for incumbent to become familiar and gain full working experience with all specified duties.

Drafted by : P. Ickx  
21 June 1988.

**ANNEX NINE**

**Good Repackaging Practices**

## GOOD REPACKAGING PRACTICES

MSH-WAREHOUSE PESHAWAR

- I. Personnel:
- (1) All workers should be free from contagious or obnoxious diseases. Their clothing shall consist of as to be suitable to the nature of work and must be clean. Adequate facilities for personal cleanliness, such as clean towels, soap and hand scrubbing brushes should be provided for each worker.
  - (2) Before starting packaging operation the workers must:
    - (a) Wash their hands before entering the room where the repackaging operation is to be performed;
    - (b) Wear either a clean cap or suitable headwear so as to avoid any possibilities of contamination by hair or perspiration.
    - (c) Wear clean cotton gloves when filling tablets or capsules, when filled by hands
  - (3) Sanitation:
    - (1) Repackaging premises should be kept clean, orderly and free from accumulated waste and vermin.
    - (2) Eating, smoking and unhygienic practices should not be permitted in the repackaging area.
  - (4) Re-packaging Operation:
    - (a) Before any packaging is begun a check should be made to ensure that all apparatus and equipment to be used in the operation has been cleaned.
    - (b) Re-packaging shall be confined to separate areas intended for such purpose and complete equipment used exclusively in those areas, or measures should be taken to ensure that neither contamination nor confusion or mix up can occur.
    - (c) Clean working Garments should be worn.
  - (5) Labelling:
    - (1) Labelling and Packaging materials should be stored and handled in such a way as to ensure that label, packaging materials relating to different products do not become intermixed and access to such materials shall be restricted to authorised personnel.
    - (2) Prior to being inserted the labels inside the containers, it should be examined and declared as satisfactory by a person who shall carefully read the label which includes product name specifications, dosage form and expiry date.

- (3) To prevent packaging and labelling errors a known number of labelling and packing units should be issued and such issuance should be made against written and signed request that indicates the quantity and type required . Upon completion of the packaging labelling operation, comparasion should be made between the number of packaging units issued and the number of items labelled and packed. Plus the number of units not used. Any significant or un-usual discrepancy in the number should br carefully investigated.

REPACKAGING OF TABLETS AND CAPSULES OTHER THAN  
ANTIBIOTICS

Deterioration of drugs can be brought about by a number of factors, the most critical of which are heat, moisture and light. Therefore the following packaging materials are recommended:

Desirable

Clean, dry plastic bottles of appropriate size with tightly sealing cap.

Less Desirable

Zip-lock plastic bags .

Not-Recommended

Paper bags, unsealed or stappled plastic bags newspaper or other printed paper.

REPACKAGING OF ANTIBIOTICS

Antibiotics are hygroscopic substances ((Very sensitive to moisture)). They should be first packed in plastic bags and then placed in plastic or tin container of appropriate size with screw or snap cap.

ANNEX TEN

Procurement Estimates till September 1989

June 1988

MEMORANDUM

TO : MSH-Team  
FROM : Paul Ickx, Associate Medical Advisor  
SUBJECT : Procurement estimations up till September 1989.

In all the estimations are not included the order requests submitted before June 1988.

All estimations are based on the assumptions that MSH will implement the number of clinics, district hospitals and provincial hospitals needed to meet the demand of 5 parties, starting July and six parties, starting September.

Also that all regional training centers, at present considered for supporting will be actively supported by September.

Also that BHW training in Peshawar will continue and expand according to the number of parties.

KEY :

BHW = Basic Health Worker  
CLI = Nurse Led Clinic  
DIH = District Hospital  
PRV = Provincial Hospital  
POS KIT = Positive Kit  
AMPUTATION = Amputation Kit

INIT = Initial supply  
RESUP = Resupply

DATES AND QUANTITIES OF DELIVERIES  
AT THE WAREHOUSE UNTIL SEPTEMBER 1989.  
Under the go-ahead scheme with  
six parties.

Kit to be delivered	July first 1989	September first 1988	December first 1988	Januari first 1989	Februari first 1989	March first 1989	April first 1989	May first 1989	June first 1989	July first 1989	August first 1989	September first 1989	October first 1989
BHW INIT	150	385	50	360	25	25	0	360	75	50	0	360	0
CLI INIT	55	20	10	10	7	7	7	7	7	7	7	0	0
DIH INIT	13	0	0	4	4	0	2	2	0	2	2	0	0
PRV INIT	5	1	0	2	1	0	1	1	0	0	0	0	0
BHW RESUP	390	237	743	240	0	562	75	334	175	750	25	537	75
CLI RESUP	35	55	20	12	44	10	26	30	60	23	46	7	16
DIH RESUP	20	0	16	6	2	0	2	26	0	14	2	0	0
PRV RESUP	3	0	0	4	1	0	2	1	0	8	0	0	0
POS KIT	200	0	0	0	0	0	0	0	0	0	0	0	0
AMPUTATION	5	0	0	0	0	0	0	0	0	0	0	0	0

ESTIMATED EXPENDITURES UNTIL SEPTEMBER 1989  
IN THE 'GO-AHEAD' SCENARIO WITH SIX PARTIES.

Kit to be supplied	June July August 1989	October November 1988	December first 1988	Januari first 1989	Februari first 1989	March first 1989	April first 1989	May first 1989	June first 1989	July first 1989	August first 1989	September first 1989
BHW INIT	412697.90	49721.43	238663.00	24860.71	49721.43	0.00	238662.90	49721.43	74582.14	0.00	238662.86	0.00
CLI INIT	232807.10	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
DIH INIT	61214.17	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
PRV INIT	71242.57	0.00	28571.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
BHW RESUP	637578.77	345102.56	202505.00	0.00	423573.30	63282.86	281819.70	147660.00	531576.00	21094.29	289413.60	63282.86
CLI RESUP	325494.27	76565.71	0.00	149303.10	0.00	61252.57	0.00	306262.90	0.00	149303.10	0.00	61252.57
DIH RESUP	81742.85	54628.57	27314.00	0.00	0.00	0.00	163885.70	0.00	81942.86	0.00	0.00	0.00
PRV RESUP	29142.86	0.00	19429.00	0.00	0.00	0.00	0.00	0.00	97142.86	0.00	0.00	0.00
POS KIT	125714.27	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
AMPUTATION	20000.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
*** Total ***	1999740.79	525018.27	516482.00	174163.81	473294.73	124535.43	684368.30	503644.33	785243.86	170397.39	528076.46	124535.43

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## ANNEX ELEVEN

### Cost Analysis of Supplies for Facilities in Afghanistan

10 May 1988.

MEMORANDUM

To : MSH-team  
From : Paul Ickx

Subject : Budget analysis of procurement of planned health facilities up till September 1989, according to "Option A",

In this analysis are not included : all standing orders up to this date.

1. Estimated cost by facility.

Cost is expressed in pakistani rupees.

1.1. Basic Health Workers

Field Kit	961.06
Initial supply	16,441.44
Resupply	14,766.04

1.2. Nurse Led Clinics

Initial Supply	74,074.93
Resupply	66,994.53

1.3. District Hospital

Initial Supply	133,905.56
Resupply	119,499.11

1.4. Provincial Hospital

Initial supply	250,000.00
Resupply	170,000.00

1.5. Positive kit

11,000.00

1.6. Emergency Kits

Initial supply	70,000.00
Resupply	21,000.00

2. Estimated expenses till September 1989.

<u>Facility.</u>	<u>Cost in rupees</u>	<u>Cost in US \$</u>
2.1. Basic Health Workers		
1385 Field Kits	1,331,068.10	75,974.21
1385 Initial Order	22,771,394.40	1,299,737.12
2967 BHW Resupply	43,810,840.40	2,500,618.76
2.2. Nurse Led Clinics		
50 Initial Order	3,703,746.50	211,401.06
238 Resupply	15,944,698.14	910,085.51
2.3. District Hospital		
8 Initial Order	1,071,244.48	61,144.09
60 Resupply	7,169,946.60	409,243.53
2.4. Provincial Hospital		
7 Initial Order	1,750,000.00	99,885.84
12 Resupply	2,040,000.00	116,438.36
2.5. Positive Kits		
280 Initial order	3,080,000.00	175,799.09
2.6. Emergency kits		
5 Initial Order	350,000.00	19,977.17
TOTAL	103,022,936.00	5,880,305.00
GRAND TOTAL ( 20% losses )	123,627,524.00	7,056,366.00

3. Estimated expenses till September 1988.

<u>Facility.</u>	<u>Cost in rupees</u>	<u>Cost in US \$</u>
3.1. Basic Health Workers		
390 Field Kits	374,813.4	21,393.46
390 Initial Order	6,412,161.60	365,990.95
265 BHW Resupply	3,913,000.60	223,344.78
3.2. Nurse Led Clinics		
50 Initial Order	3,703,746.50	211,401.06
84 Resupply	5,627,540.50	321,206.64
3.3. District Hospital		
8 Initial Order	1,071,244.48	61,144.09
12 Resupply	1,433,989.30	81,848.70
3.4. Provincial Hospital		
5 Initial Order	1,250,000.00	71,347.03
3 Resupply	510,000.00	29,109.59
3.5. Positive Kits		
140 Initial order	1,540,000.00	87,899.54
3.6. Emergency kits		
5 Initial Order	350,000.00	19,977.17
TOTAL	26,186,493.00	1,494,663.40
GRAND TOTAL ( 20% losses )	31,423,792.00	1,793,596.00

28 June 1988.

MEMORANDUM.

TO : Team  
FROM : Paul.

SUBJECT : Ratio of drugs, expendible supplies and equipment for facilities inside Afghanistan as estimated at this date.

	DRUGS	EXPENDIBLE SUPPLIES	EQUIPMENT	TOTAL IN RUPEES
BHW Satelite Clinics :	75%	12%	13%	16,441.44
Nurse Led Clinics :	71%	17%	12%	74,074.93
District Hospitals :	68%	22%	10%	133,905.56
Provincial Hospitals :	62%	22%	16%	250,000.00

Remarks :

1. For Provincial Hospitals TB-treatment will increase the percentage of drugs.
2. Estimates need to be updated with actual prices, propably by end of July.

ANNEX TWELVE

Tuberculosis Treatment in Afghanistan

20 June 1988.

MEMORANDUM

TO : Team

FROM : Paul Ickx, M.D., Associate Medical Advisor

SUBJECT : Tuberculosis treatment inside Afghanistan.

Tuberculosis is a major health problem in Afghanistan. It is hardly suprising that Afghan medical people confronted with the problem request drugs for treatment. However, a clear distinction should be made between providing tuberculostatics to some health facilities and the implementation of a control program.

A TB Control Program seems hardly feasible at this time : nobody can take the responsibility for it.

However, after consulting Dr. Piva, M.D. head of the Italian Cooperation for Development and responsible for the TB Control Program among Afghan Refugees in N.W.F.P., it became clear that certain measures could be considered.

The major problem are the people who have active TB and are a source of contamination for their environment. An attempt could be made to treat those people. This limits the treatment in practice to those patients who are AFB positive on sputum examination. It also limits the implementation of treatment to those facilities who have laboratory equipment and a staff, familiar with the Ziehl-Nielsen coloration.

Dr. Piva emphasized the need to limit the implementation of TB treatments to those facilities whose staff fully understands the danger of introducing a lasting resistance of BK against the commonly used tuberculostatics.

In practice, MSH should only provide tuberculostatics to "Provincial Hospitals" with well equipped laboratory. Along with the drugs strict guidelines for case-finding and treatment should be distributed.

At this point it seems hardly adviseable to use any other treatment portocol than the one already in use for Afghan refugees. In the present situation, where refugees might return at any moment, any treatment introduced in Afghanistan should match with the treatment

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used presently for the refugees. In case of return, it will improve the probability of finishing a complete treatment course.

The I.C.D. uses two treatment protocols. A Standard Regime of 12 months (2 months SHT and 10 months HT) and a Short Course Regime of 8 months (2 months SRZH and 6 months HT), used for AFB positive patients only.

Dr. Piva strongly suggested the use of the Short Course Regime inside Afghanistan, since in any unstable situation a shorter treatment schedule is more likely to be completed.

Both schedules use Thiacetazone (T), a drug listed as ineligible by USAID. Steve Solter and Stephen Sacca suggested that MSH/Peshawar should try to get a waiver to use the drug Thiacetazone from USAID/Islamabad on the ground that the drug is widely used in the TB Control Program among Afghan Refugees, and that implementing a still different treatment course inside Afghanistan would only increase the confusion that will accompany the return of Afghan refugees.

I would suggest that MSH submits the request for a waiver concerning Thiacetazone to USAID/Islamabad in the grounds stated above.

ANNEX THIRTEEN

Morbidity and Health Facility Data - Afghanistan

7 June 1987.

MEMORANDUM

TO : MSH team  
FROM : Paul Ickx, Associate Medical Advisor

SUBJECT : Some data on morbidity and health facilities inside  
Afghanistan

1. Morbidity.

1.1. CMC - data. (IMC,MSF)

Cfr. Annex 1.

This gives a rough insight in pathology encountered inside Afghanistan in various health centers.

"Ghazni" based on six week consultation of two dutch M.D., at the end of a six month stay in the same clinic. August - September.

"Badakhshan 2000" data compiled on two two month summer consultations and one four month winter consultation by dutch and french M.D. and paramedics.

"Badakhshan 1500" data compiled on four two month summer-fall consultations by expatriate staff.

"Hazarajat" data from a three month fall consultation and a five month winter consultation.

"Balkh" data from a six month winter - spring consultation.

"Compiled data" from greenbooks of six to nine months trained afghan health workers all over Afghanistan.

1.2. Swedish data

Out of a "Green Book"

Gives 7.8 % "Infectious Diseases", 5.1 % Surgical cases and 87.1 % "Other"

1.3. Afghan impressions.

Hard data being difficult to come by, another source are the impressions, both from medical people and nonmedical people from different regions of Afghanistan.

A major problem in a lot of cases is malaria. The situation can be compared with what existed before the implementation of the Malaria Control Program.

The lowlands of the former Qataghan province (Kunduz, Baghlan, Takhar) and the eastern provinces can be considered hyperendemic. The Hari Rud valley, Badakhshan valleys, Kunduz mountains, Helmand valley and Registan should be meso-endemic.

All regions between 1500-2000 meter altitude are at least hypo-endemic.

Normally, one will not find malaria above the 2000 meter. However, the coming and going of people between the different regions of Afghanistan and between Afghanistan and the neighbouring countries certainly accounts for a more than normal number of imported cases even in those areas.

Several reports of what seems to be cases of cerebral malaria give way to the presumption that the old pattern of malaria has been reinstalled. Early infestation in late spring and early summer with Vivax gives way, certainly in the hyperendemic regions for Falciparum.

In addition to the normally existing breeding places for the vectors, one has to take in consideration the disruption and destruction of irrigation canals, which in certain regions were partially drainage canals.

Tuberculosis was and is a major problem for all regions and all ethnic groups.

Lepra still seems confined to the Hazara?

Anthrax has been reported, mainly by expatriates, from the Northern Provinces.

Childhood diseases (EPI-target diseases) account for the death of 20 to 60% percent of under fives, varying with region and source of information. Most small local surveys speak of 30 - 40 %.

Intestinal parasites (roundworms, giardia, amoeba,...) are abundant.

Respiratory and skin infections and their complications make up one third or more of pathology

Localized epidemics have been reported regularly.

Almost every year reports about "cholera" epidemics in the dry season are made from various provinces.

From Zabul, Logar and Wardak, unsubstantiated rumours of limited outbreaks of "smallpox" have been heard.

Nutritional status as a whole is not alarming, but borderline. In most rural regions where people did not immediately leave in 1980-1981, lack of food has been a major cause for becoming refugee. The relative draught in 1984-1985-1986, combined with systematic destruction of scarce crops by the Soviet and government army have caused the exodus of certain areas (Ialmi areas of the north). Displaced persons in the northern and central provinces are of course

most prone to the possible danger of malnutrition. They benefit most from the "cash for food" and "cash for job" programs.

Typhoid fever is reported extremely frequently by lowly trained personnel.

A sensitive problem are the amputated. The intervention is often performed by people with little experience, prostheses are difficult to come by and often impossible to fit on the stump. Most of the amputated are victims of the anti-personal mines. The result are complete families without their regular source of income, because it are most often the young and active out in the field who are maimed. The Health Administration of Herat counts more than 2000 of cases registered for assistance.

## 2. Foreign committees inside Afghanistan.

### 2.1. Foreign medical staff inside Afghanistan.

AMI has no longer permanent or semi permanent health facilities staffed by foreign health officers inside Afghanistan. Efforts are concentrated on formation of afghan health workers in the M.T.A. and the follow-up in the field of the students.

In 1987 an evaluation team went to the North-East region to check up on students from training programs of C.M.C. members and A.H.C. trainees.

AVICEN sends in foreign supervisors to the border provinces, where its trainees conduct small vaccination campaigns under supervision of expatriates, before going out alone on more distant missions.

CAP ANAMUR, Deutsche Notartze, has one hospital in Bamyan, staffed by expatriates.

MDM has a well-equipped and well-staffed surgical hospital in Wardak. It serves as a referral hospital for several clinics staffed by afghan health workers in the same area.

MSF-France has one hospital in Ghazni staffed with foreign doctors. Two facilities in Badakhshan were left in the care of locally trained afghan health workers, as happened before in wintertime. They should be restaffed with foreigners this summer. Successful vaccination campaigns, carried out by expatriates, are going on in Ghazni and Paktia.

MSF-Netherlands and MSF-Belgium have a hospital staffed with a foreign team in Parwan, with the sji'a.

NCA has intermittently foreign doctors in Ghazni, in a mobile outfit. Expatriates supervise also the vaccinations carried out by afghans.

All of those groups have difficulties finding medically qualified people, able to adapt to the afghan reality. All, even the most "ret

NCA in Ghazni (Tangay) EPI with OPV, with some 10,000 (?) children vaccinated by Afghans under supervision(?) of foreign technicians.

MSF in Badakhshan (Yaftal), Hazarajat (Jaghori) BCG and measles, done under doubtful conditions regarding cold chain, but with a total of 6000 (Yaftal) and 20,000 (Jaghori) children vaccinated.

MSF in Fakhria (Ziruk) EPI with IPV, in September - November 1987.  
Years 0-1 : 45 DTP2, 65 measles, 73 BCG  
Years 1-4 : 699 DTP2, 848 measles, 862 BCG  
Years 5-14 : 477 DTP2, 620 measles, 638 BCG  
Campaign executed by foreigners, relying on prestige of local nurse gave very positive response. All neighbouring valleys demanded immunization.

MSF in Ghazni (Warghaz) EPI with IPV, in January-March 1988.  
Coverage study in May 1988 shows 92% coverage of target population. Close to 3500 children fully immunized.  
Campaign executed by foreigners, relying on prestige of foreign clinic and local administrator. Very positive response.

## 2. Some data on health.

Pre-war population 13 million, and close to 2 million nomads. In the 13 M, 6.68 M males and 6.32 M females. 11.1 (87%) rural, 1.9 M (13%) urban with more than 50% in Kabul.  
Crude birth rate of 48/1000 and a population growth rate of 26/1000.

About 5 million exiled (Pakistan, Iran and elsewhere)  
About 2 million internally displaced in rural areas.  
About 1.5 million displaced towards the cities (mainly Kabul).  
About 1 million died.

Infant mortality estimated in 1979 to be 187/1000  
Survey in Hazarajat in 1984, retrospective questioning of 670 married women, gave 283,76/1000 deaths before the age of five. Very young children had often "been taken away by fin" = neonatal tetanus?  
Other areas, Nuristan e.g., indicate even higher under five mortality, close to 400/1000.

Various small scale nutrition surveys (most of them using mid-arm circumference) indicate about 30% of children to be borderline malnourished.

Birth attendance in Afghanistan before the war was done for 60% by TBAs, of which only 4% had some kind of training.  
Inaccessibility of the mainly urban health facilities for the rural population due to the war has increased the reliance on TBAs.

### 2.1. Health facilities government side.

Before the war:

151 Basic Health Centers  
 75 Subcenters  
 35 MCH clinics  
 66 Hospitals with a total of 3666 hospital beds (.3/1000), of which 60% located in the capital.  
 Institute of Child Health has 250 beds (150 medical and 100 surgical).

Efforts to train more health technicians after the exodus of M.D. and trained nurses in the beginning of the war, led to the creation of the "assistant doctor", a three year training.

At least 250 people have had initial or refraiment training as vaccinator.

Various BHW posts are claimed to be in existance, but never confirmed by resistance sources.

Various lowly-trained healthworkers are still getting smuggled supplies from city hospitals and work rural 'bazars'.

## 2.2. Hospital pathology.

Hospitals under regime control are understaffed and depending on expatriate M.D. Admission is restricted mainly to party members and military.

Males between 15 and 45 risk forcefull enlistment in the army, others coming from resistance controlled areas fear harassment.

All functioning hospitals in resistance controlled areas have city people visiting the hospital. Those with operational x-ray or laboratory get not seldom patients referred by Afghans doctors of city hospitals.

Pathology in 1981 in the Institute of Child Health, cfr annex.

Expatriate run Hospital in Jaghori in 1983.

Age repartition of visits (OPD)

	Male	Female
<5 years	1.9	14.0
5-14 years	14.0	15.5
>15 years	84.1	70.5

Origin of Patients in walking distance from hospital, 1 day=8hours (OPD) Maximum distance 11 walking days, winter period means 1.5 to 3meters of snow.

	Male	Female	
		Other seasons	Winter
<3h	45.3	49.3	86.8
3h-8h	49.6	42.8	13.2
2d-5d	4.0	4.9	
>5d	1.0	3.0	

Pathology of 404 hospitalized patients cfr annex.

known", foreign medical implantations have been temporarily interrupted or come to a complete stop due to cultural clashes between afghans and foreigners. Nevertheless, many regions in Afghanistan have an explicit demand for foreign medical assistance, mainly because afghan M.D. refuse to work under the harsh conditions of the afghan countryside.

## 2.2. Foreign committees as suppliers.

S.C.A. supplies regularly drugs, medical supplies and salaries to a large number of afghans. The medical knowledge of the people supplied varies from graduated M.D. to self-made 'doctor sa-heeb'. Applicants are evaluated for medical knowledge by afghan M.D. in the S.C.A. and given a kit with drugs and medical supplies according to their knowledge.

GAC supplies on a similar basis a number of health facilities inside Afghanistan.

## 2.3. Medical training programs.

AVICEN has training courses for vaccinators, who are then supplied with vaccines and cold chain to go inside Afghanistan. So far 30 vaccinators have been trained. Avicen gives introductory lectures on immunization in other training courses. Is also sub-contracted to assist in the training of AHC vaccinators.

Freedom Medicine has a six month training course, and has turned out XXX trainees.

Health unlimited has in cooperation with an afghan doctor a 9-month training course in Quetta. 20 students per session, no graduates so far.

IMC has a eight month training course of 40 students per session. About 100 graduates so far.

MCI has three and six months training course plus special technical formations (X-ray, laboratory)

MTA has a eightteen months training course of 15 - 20 students per session. One session every nine months. Two sessions graduated, third graduates september 1988.

The trainees of these groups are taken in charge regarding medical supplies and salary by the organization who trains them, or by S.C.A. or by A.H.C.

A fair number of these students man facilities in the regional organizations discussed further down.

## 2.4. Coordination between the foreign medical committees.

Although informal coordination between those committees present

inside Afghanistan has always existed, formal coordination between all the committees has proven to be very difficult.

The Coordination of Medical Committees has been meeting for more than two years. Since then it has not yet come to a clear definition of its task.

Some of the major difficulties :

- not all medical committees involved in cross border medical aid are member, some even actively barred from membership.
- the majority of the representatives of the different committees in CMC have very limited (one area, one commander) or no experience inside Afghanistan. Their major source of information limits itself to the Peshawar scene.

The phrase "We are working with the commanders", implying direct and independent interaction between commanders from inside and PVD is untrue for the majority of the committees. In fact, only those sending in foreign teams have direct contact with commanders. All others pass through party recommendations to get in contact with the commanders.

### 3. AHC.

AHC is the Alliance Health Committee, technically assisted by Management Sciences for Health to increase health services inside Afghanistan in the resistance controlled areas.

So far four party health responsables have been cooperating : Jamiat, Mahaz(NIFA), Jebhe(ANLF) and Harakat Enqelaab.

The others refuse for various reasons.

#### 3.1. Training.

Every four months 240 Basic Health Workers graduate from a three month medical course, get supplied with drugs, medical equipment and salaries and go inside to work. They come back to Peshawar for resupply every three, six or twelve months, according to distance.

A buddy-care program is carried out in camps to teach life-saving first aid to mujaheddin.

A two month vaccinator course is set up, in cooperation with AVICEN, preparing 24 vaccinators for pilot campaigns inside Afghanistan.

#### 3.2. Health facilities inside Afghanistan.

At this moment some 570 BHW are working in Afghanistan.

Actually some 46 clinics are being supplied also. A "clinic" is a health facility where the total amount of months of formation of the total medical staff adds up to at least 30. 50 more are planned this summer.

The idea is to have provincial hospitals, equipped with specialized staff, district hospitals with at least one MD supervising clinics (as described above) who in turn supervise B BHW. The system permits already now in some areas centralization of logistics without disrupting regional power structures.

#### 4. Regional health systems inside Afghanistan.

In two areas, the mujaheddin have set up a health administration, covering several districts, if not provinces. Both have been set up in areas controlled by commanders affiliated with Jamiat : Ahmad Shah Massud and Ismail Khan.

The basic ideas are similar. With a core of a few MD and nurses, people coming from the different training programs in Peshawar and Quetta are tested for practical medical knowledge and sense of responsibility, before being consigned to a particular health facility, under supervision of the central health administration.

In 1988 in both regions, local training programs for BHW of 3 months have been started in order to prevent loss of time (and lifes) on a long and risky journey to Pakistan.

##### 4.1. Nord East.

Comprises the region under control of the Supervisory Council of the North. The Council appointed Dr. Sahar as Regional Responsible of Health. In 1986 Dr. Sahar came to Peshawar, stayed for more than six months to contact all foreign medical committees he deemed suitable. He placed 60 students in the different training programs. He contacted AHC(MSH), SCA and NAC for medical supplies for health facilities already existing.

Actually in existence under the regional administration : cfr annex 4.

The most positive point in these regional health systems, is that they are incorporated in a bigger social and administrative structure. This permits for example road building between clinics and hospital for smoother referral of patients.

##### 4.2. West.

Dr. Mahmud Shah (Darweish) is similarly the responsible of health of Ismail Khan's administration. He has at least one health facility in each district or subdistrict, incorporated in the administration. He has some 80 people in his organisation of different levels.

A three month training program is running in the central hospital.

He placed also students in the different training programs. Contacted also several committees for support.

Logistically, the area is flat and very shaky regarding safety. Of the original six M.D. in the system, two were buried alive in their underground hospital when it was bombed. A third one had to leave. A fourth one changed his clinic 17 times last year, to avoid military reprisals against his outfit.

#### 4.4. Elsewhere.

The two examples explained above are a stimulation for similar projects. However, few areas have the same political and military stability necessary to implement such administrations.

The very suspicious attitude of the major foreign committees in Peshawar towards these two initiatives reflects the difficulties the foreigners have to adapt to the idea of afghans running their own health system.

#### 5. Planning for the future.

- MSH should take care for future implementation to :
- strengthen as much as possible local administrations under any form (tribal or party based)
  - implement further clinics, hospitals and BHW posts according to present and/or future needs on population basis (Cfr. Field Operations : Health facilities needed on basis of population estimates).

FATHOLOGY IN AFGHANISTAN IN VARIOUS HEALTH STATIONS.

Pathology encountered	Ghazni	Badakhshan	Badakhshan	Hazarajat	Palkh	Compiled
	elevation 2000 m.	elevation 2000 m.	elevation 1500 m.	elevation 2500 m.	elevation 750 m.	data.
<b>## CARDIOVASCULAR</b>						
HYPERTENSION	0.5	1.4	0.9	1.4	2.3	1.3
OTHERS	0.9	0.6	0.2	1.1	1.2	0.6
<b>## Subtotal ##</b>	<b>1.4</b>	<b>2.0</b>	<b>1.1</b>	<b>2.5</b>	<b>3.5</b>	<b>1.9</b>
<b>## DEFICIENCY DISORDERS</b>						
ANEMIA	1.8	2.2	0.9	0.6	1.2	1.6
DEHYDRAT	0.1	0.0	0.0	0.1	0.0	0.8
GOITER	0.0	0.1	0.1	0.8	0.3	1.0
MALNUTRITION	0.0	0.2	0.3	0.5	0.4	0.7
<b>## Subtotal ##</b>	<b>1.9</b>	<b>2.5</b>	<b>1.3</b>	<b>2.0</b>	<b>1.9</b>	<b>4.1</b>
<b>## EAF</b>						
MEDIAL OTITIS	2.0	3.2	2.2	1.8	4.6	3.0
OTHERS	0.4	1.4	1.4	0.8	1.4	1.1
<b>## Subtotal ##</b>	<b>2.4</b>	<b>4.6</b>	<b>3.6</b>	<b>2.6</b>	<b>6.0</b>	<b>4.1</b>
<b>## EPI-TARGET DISEASES</b>						
DIPHTERIA	0.0	0.0	0.0	0.0	0.0	0.4
MEASLES	0.0	0.0	0.0	0.3	0.0	0.9
PERTUSSIS	0.0	0.1	0.0	0.6	0.0	0.5
TBC	0.3	2.2	1.6	3.4	3.4	0.0
<b>## Subtotal ##</b>	<b>0.3</b>	<b>2.3</b>	<b>1.6</b>	<b>4.3</b>	<b>3.4</b>	<b>1.9</b>
<b>## EYE</b>						
CONJUNCTIVITIS/TRACHOMA	4.2	6.0	10.9	5.9	6.4	3.7
OTHER	2.8	3.5	2.0	1.4	1.8	0.1
<b>## Subtotal ##</b>	<b>7.0</b>	<b>9.5</b>	<b>12.9</b>	<b>7.3</b>	<b>8.2</b>	<b>3.8</b>
<b>## GASTRO-INTESTINAL</b>						
DIARRHEA	1.9	2.4	2.8	3.2	2.6	5.5
GASTRITIS/ULCEP	9.9	5.6	5.9	7.7	8.6	-
PARASITES	19.0	10.0	15.4	11.3	11.6	8.0
VAGUE COMPLAINTS	2.5	3.5	3.5	2.2	1.3	3.3
<b>## Subtotal ##</b>	<b>33.3</b>	<b>21.5</b>	<b>27.6</b>	<b>24.4</b>	<b>24.1</b>	<b>24.4</b>
<b>## GENERAL SYMPTOMS</b>						
MALAISE	8.5	0.0	0.0	2.1	10.4	1.1
<b>## Subtotal ##</b>	<b>8.5</b>	<b>0.0</b>	<b>0.0</b>	<b>2.1</b>	<b>10.4</b>	<b>1.1</b>
<b>## GENITO-URINARY</b>						
HIGH URINARY TRACT INFECTION	0.0	0.0	0.0	0.3	0.5	0.7

PATHOLOGY IN AFGHANISTAN IN VARIOUS HEALTH STATIONS.

Pathology encountered	Ghazni elevation 2000 m.	Badakhshan elevation 2000 m.	Badakhshan elevation 1500 m.	Hazarajat elevation 2500 m.	Balkh elevation 750 m.	Compiled data.
INFERTILITY	0.5	1.0	0.4	0.9	0.9	0.0
LOW URINARY TRACT INFECTION	1.1	1.2	0.0	3.1	1.9	1.7
MALE GENITAL DISORDERS	0.1	0.2	0.0	0.1	0.5	0.7
URINARY STONES	0.0	0.1	0.0	0.1	0.1	0.1
## Subtotal ##	1.7	2.5	0.4	4.5	3.9	3.2
## GYNECO-OBSTETRICS						
DELIVERY/DYSTOCIA	0.1	0.2	0.0	0.5	0.0	0.1
GYNECO INFECTION	0.0	0.2	0.3	0.1	0.1	0.2
## Subtotal ##	0.1	0.4	0.3	0.6	0.1	0.3
## INFECTIOUS DISEASES						
HEPATITIS	0.0	0.0	0.0	0.1	0.0	0.0
LEPRA	0.0	0.0	0.0	0.1	0.0	0.0
MALARIA	0.1	5.4	8.3	0.2	1.2	0.4
TYPHOID	0.0	0.0	0.0	0.0	0.0	0.7
## Subtotal ##	0.1	5.4	8.3	0.4	1.2	1.1
## MOUTH						
DENTAL PROBLEM	1.1	1.7	2.0	1.4	3.7	0.2
## Subtotal ##	1.1	1.7	2.0	1.4	3.7	0.2
## MUSCULO-SKELETAL						
ARTRALGIA	19.1	12.0	11.8	16.1	2.2	7.9
INFECTIOUS	0.1	0.5	0.4	0.3	2.1	0.0
R.A.	1.5	0.6	0.3	0.5	1.4	1.7
STRAIN/SPRAIN	0.0	6.7	0.0	1.2	0.0	6.2
## Subtotal ##	20.7	19.8	12.5	18.1	5.7	16.0
## NEURO-PSYCHIATRIC						
DEPRESSION/ANXIETY	0.3	0.5	0.5	1.0	0.7	0.9
EPILEPSY	0.1	0.3	0.2	0.3	0.1	0.0
MEMINGITIS	0.0	0.0	0.0	0.0	0.1	0.7
OTHERS(INCL. HEADACHE)	4.0	3.3	4.9	2.6	3.6	0.6
## Subtotal ##	4.4	4.1	5.6	3.9	4.5	2.2
## RESPIRATORY/HIGH						
COMMON COLD/COUGH	7.0	5.3	2.5	4.5	3.2	8.3
## Subtotal ##	7.0	5.3	2.5	4.5	3.2	8.3
## RESPIRATORY/LOW						
BRONCHITIS/PNEUMONIA/ASTHMA	4.8	6.9	7.7	14.4	9.1	13.8

PATHOLOGY IN AFGHANISTAN IN VARIOUS HEALTH STATIONS.

Pathology encountered	Ghazni	Badakhshan	Badakhshan	Hazarajat	Balkh	Compiled
	elevation 2000 m.	elevation 2000 m.	elevation 1500 m.	elevation 2500 m.	elevation 750 m.	data.
## Subtotal ##	4.8	6.9	7.7	14.4	9.1	13.8
## SYIN						
ALLEGY/ATOPIC /UNSPECIFIED	1.4	3.3	2.5	1.9	2.5	1.9
ECTO-PARASITES	0.0	0.6	0.4	1.2	1.2	0.9
INFECTIOUS	3.5	2.7	3.0	3.5	3.1	3.0
## Subtotal ##	4.9	6.6	5.9	6.6	6.8	5.8
## TRAUMA						
BURNS	0.0	0.2	0.3	0.1	0.7	0.0
NOT WAR RELATED	0.0	0.2	0.3	0.1	0.7	0.0
WAR RELATED	0.0	0.2	0.3	0.1	2.6	0.1
## Subtotal ##	0.0	0.6	0.9	0.3	4.0	0.1
### Total ###	99.6	95.7	94.2	99.9	99.7	92.2

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ANNEX FOURTEEN

Health Data on Afghanistan

# KABUL

## Morbidity and mortality in childhood in Afghanistan 27

Table II Age and sex distribution of 40492 consecutive admissions and their correlation with mortality

Age group	No of patients		Total	Percentage of total patients	No. of deaths	Death rate (%)	Percentage of total deaths
	Male %	Female %					
0-4 weeks	1339 (68.0)	630 (32.0)	1969	4.9	640	32.5	20.0
1-11 months	6543 (63.3)	3757 (36.5)	10300	25.4	812	7.9	25.4
1-4 years	11184 (61.4)	7042 (38.6)	18226	45.0	1157	6.3	36.3
5-9 years	3816 (61.4)	2401 (38.6)	6217	15.4	369	5.9	11.6
10-14 years	2619 (69.3)	1161 (30.7)	3780	9.3	213	5.6	6.7
Total (0-14 years)	25501 (63.0)	14991 (37.0)	40492	100.0	3191	7.9	100.0

12269 (40.2%) were infants below one year of age. Males were preponderant at all ages and accounted for 63% of all patients.

### III. Mortality pattern

Table III shows the primary diagnoses or groups of diseases in relation to age. Gastroenteritis and respiratory infections together accounted for about half (49.9%) of all admissions. Septicaemia was responsible for 8.1% of hospital admissions and one third of patients with septicaemia were newborn babies. Mal-

nutrition as a primary diagnosis was recorded in 2764 (6.9%) children. Analysis of the weight-for-age of all the children revealed that 19% had Grade III or IV degree of protein energy malnutrition, based on the criteria recommended by the Indian Academy of Pediatrics (1). By and large, 67% of children had varying grades of undernutrition as an associated feature and consequently fell prey to infectious diseases. In all, 28159 (70.7%) children were admitted to the hospital with a variety of infective disorders. Admissions of a large number of children with multiple injuries (4.9%) is a temporary phenomenon related

Table III Morbidity and mortality and their main causes numbers (%)

Primary diagnosis	0-4 weeks	1-11 months	1-4 years	5-9 years	10-14 years	Total	Percentage		Case fatality rate (%)
							of total morbidity	No. of deaths	
Gastroenteritis	239 (1.7)	5720 (40.5)	6415 (45.4)	1152 (8.1)	599 (4.2)	14125	35.5	637	4.5
Respiratory infections	201 (3.5)	1219 (21.3)	2532 (44.3)	1268 (22.2)	500 (8.7)	5720	14.4	463	8.1
Septicaemia	1076 (33.3)	485 (15.0)	699 (21.7)	504 (15.6)	462 (14.3)	3226	8.1	579	17.9
Malnutrition	59 (2.1)	694 (25.1)	1665 (60.2)	227 (8.2)	119 (4.3)	2764	6.9	193	7.0
Haematological disorders	74 (4.7)	278 (17.6)	693 (44.0)	307 (19.5)	223 (14.1)	1575	3.9	71	4.5
Tuberculosis	1 (0.1)	33 (4.5)	219 (30.0)	298 (40.8)	179 (24.5)	730	1.8	80	10.5
Diphtheria, pertussis, tetanus	81 (10.7)	101 (13.4)	226 (30.0)	210 (27.8)	136 (18.0)	754	1.9	131	17.4
Polio-myelitis	1 (0.8)	11 (8.7)	32 (25.4)	53 (42.1)	29 (23.0)	126	0.3	4	3.2
Measles	—	174 (12.4)	902 (64.3)	302 (21.5)	24 (1.7)	1402	3.5	116	8.3
Typhoid	3 (0.3)	19 (2.1)	109 (12.0)	473 (52.1)	303 (33.4)	907	2.3	38	4.2
Neoplasms	8 (1.3)	60 (9.7)	174 (28.0)	204 (32.8)	175 (28.2)	621	1.5	35	5.6
CNS disorders and infections	53 (4.5)	349 (29.8)	384 (32.8)	211 (18.0)	172 (14.7)	1169	2.9	246	21.0
Genitourinary diseases	36 (3.5)	112 (10.8)	237 (22.8)	428 (41.2)	225 (21.7)	1038	2.6	27	2.6
Hepatic disorders	61 (8.9)	67 (9.0)	203 (29.6)	203 (29.6)	151 (22.0)	685	1.7	63	9.2
Cardiovascular disorders	10 (4.6)	36 (16.5)	73 (33.5)	44 (20.2)	55 (25.2)	218	0.5	31	14.2
Intestinal obstruction	40 (9.0)	115 (26.0)	157 (35.5)	87 (19.7)	43 (9.7)	442	1.1	107	24.2
Multiple injuries	4 (0.2)	51 (2.6)	514 (26.0)	1003 (50.8)	403 (20.4)	1975	4.9	200	10.1
Burns	3 (0.4)	58 (8.7)	338 (50.5)	191 (28.5)	79 (11.8)	669	1.7	90	13.4
Poisonings	17 (7.2)	43 (18.3)	93 (39.6)	51 (21.7)	31 (13.2)	235	0.6	21	8.9
Malformations	245 (16.9)	497 (34.2)	472 (32.5)	129 (8.9)	108 (7.4)	1451	3.6	59	4.1
Total	2212 (5.5)	10122 (25.4)	16137 (40.5)	7345 (18.4)	4016 (10.1)	39832	100.0	3191	8.0

Gastroenteritis includes dysentery and food poisoning. Tuberculosis includes TBM. Neoplasms includes leukaemia. Data includes 660 children with miscellaneous disorders which could not be categorized into above broad groups, but there was no death among these patients.

Table IV Stool examination reports of 7507 children attending polyclinic

No. examined (%)	<i>Ascaris</i>	<i>Giardia</i>	<i>E. histolytica</i>	<i>H. nana</i>	<i>E. coli</i>	<i>Trichuris trichiura</i>	<i>T. sallum</i>	<i>T. spiralis</i>	Total positive cases
7507 (100.0)	4341 (57.8)	1316 (17.5)	596 (7.9)	411 (5.5)	169 (2.2)	87 (1.1)	3 (0.04)	18 (0.2)	6591 (92.6)

Number of children with ova/cysts of at least 2 parasites 1820 (24.2%).

Number of children with ova/cysts of at least 3 parasites 73 (1%).

to the prevailing socio-political conditions in the country. Helminthic and other parasitic infestations, though ubiquitous in Afghanistan, were seldom recorded as a primary diagnosis except when they were associated with life-threatening complications. During the study period, 225 children were admitted with intestinal obstruction due to ascariasis. Screening of stool specimens of 7507 children attending the polyclinic showed some helminthic or parasitic infestation in 92.6% of cases (Table IV). Among 1038 children with genitourinary disorders, 673 children were admitted with nephrolithiasis.

#### Mortality pattern

The overall mortality of the children admitted to hospital was 7.9% (Table II). The death rate was highest (32.5%) among sick newborn babies, while among the other age groups it only varied from 5.6 to 7.9%. 81.7% of total deaths occurred in children under five years of age. Infectious diseases accounted for 2294 deaths (71.9%). Gastroenteritis and respiratory infections together caused 34.5% of all deaths. The case fatality rate of acute respiratory infections was almost twice that of acute gastroenteritis. Deaths due to six-target diseases preventable by standard vaccinations, e.g. tuberculosis, diphtheria, pertussis, tetanus, poliomyelitis and measles contributed to 10.4% of overall mortality. Malnutrition as a sole or primary cause of death accounted for 193 deaths (6%). Among fatal cases, the incidence of severe malnutrition (Grades III and IV) was 36.7%. Septicaemia and infections of the central nervous system were associated with the highest case fatality rate and accounted for 825 deaths (25.8%). Accidents, i.e. multiple injuries, burns and poisonings were the cause of 311 deaths (9.7%).

Most children were brought to the hospital in a moribund condition so that 63% deaths occurred within 24 hours of admission. It was revealing to observe that the majority (83.8%) of deaths occurred during the evening or night, after the regular working hours of the hospital when only skeletal medical and nursing staff were on duty.

#### Discussion

Hospital-based data on morbidity and mortality of children are not truly representative of their incidence in the community as a whole. Nevertheless, they do reflect the pattern of prevailing serious childhood diseases with their outcome. The Institute of Child Health, Kabul is an exceedingly busy hospital which, each day, dispenses ambulatory care to around 400 children and in-patient attention to 40 seriously sick patients. Due to shortage of beds, the turnover of patients is very rapid as evidenced by a short average stay in hospital. The preponderance of boys is in keeping with observations in other reports from developing countries and is caused by parents' greater concern for the welfare of their male rather than female offspring (2). The greater vulnerability of under-five children is evident because 75.3% of our patients were below the age of five years.

Two-thirds (67%) of our in-patients were undernourished although life-threatening malnutrition as a primary diagnosis was made in only 6.9% of cases. It would appear that protein energy malnutrition is a core problem which renders children susceptible to various infections (3). The poor environmental sanitation provides ample opportunities for development of water-borne infections which triggers the vicious cycle of malnutrition and infections. It is interesting that every year there is an increased incidence of protein-energy malnutrition at the beginning of winter as an aftermath of summer diarrhoea. Fortunately, breast feeding in Afghanistan is almost universal, but bottle feeding is introduced by 25% mothers before the baby is six months old. Breast feeding is often interrupted when the mother becomes pregnant again, which happens too often and too soon. There is lack of knowledge regarding dietary needs of young children, weaning is often delayed and feeds are prepared unhygienically. A dummy nipple as a pacifier is used by 60% of mothers in Kabul, which contributes to under feeding because the mother responds inappropriately when her child cries with hunger. Food is often withheld during fever, especially when associated with an exanthematous illness or diarrhoeal episode, thus aggravating the malnutrition.

12 June 1988.

MEMORANDUM

SUBJECT : Some numbers on health inside Afghanistan.

1. Immunization.

1.1. From government side.

Kabul. From November 1984 to April 1986 : a special EPI-campaign. Results : out of a survey of 211 children, 85% appeared fully immunized according to immunization records and histories provided by mothers. Target population was 84,000.

Women with 2 doses of tetanos toxoid give 54% coverage. Target population was 317,000.

Reach out campaigns failed

Mazar i Sharif. No coverage studies, campaign April 1986 - April 1987.

Years 0-1 : 56,475 DPT3, 32,799 measles, 56,980 BCG

Years 1-4 : 60,620 DPT3, 42,280 measles, 34,537 BCG

Years 5-14 : 71,738 DT2

Women 15-44 : 51,109 TT2

Reach out outside the city not possible.

Jawzjan province (center). No coverage studies, campaign Januari - March 1986. Results of activities difficult to interpret.

Reach out not possible.

Nangrahar (Jalallabad). No coverage studies.

Years 0-1 : 18,694 DPT3, 18,250 measles, 21,692 BCG

Years 1-4 : 12,218 DPT3, 16,147 measles, 14,403 BCG

Years 5-14 : 36,225 DT2

Women 15-44 : 19,623 TT2

1.2. Resistance controlled areas.

Immunization efforts have been limited to some FVO and an occasional village, vaccinated with vaccines stolen from the government by a local health worker.

Avicen in several places, training ground (Faktia - Tani) with IPV, rest BCG and measles.

MDM in Wardak (Jaghathu) where some 10,000 children have been fully vaccinated. In Kunar several trials met with very bad results due to lack of established health facility to rely upon.

Cita in Nuristan. 1987.

Years <6 : 651 DPT2, measles ?, 651 BCG

Women 15-44 : 659 TT2

10/2

JAGHORI  
HOSPITALISATION 1983

- 19 -

	Enfants <5Y	Jeunes 5-14Y	Adultes >15Y	Total	X
OPHTALMO					
Intervention sur entropion	-	-	2	2	
ORL-STOMATO					
Angine fébrile	-	1	1	2	
Parotidite	-	-	1	1	
CARDIO-VASCULAIRE					
Insuffisance cardiaque	6	3	25	34	8,42
Hypertension artérielle	-	-	2	2	
Arythmie	-	-	1	1	
Embolie pulmonaire	-	-	1	1	
Infarctus	-	-	7	7	
PNEUMO					
Bronchopneumopathie	26	6	30	62	15,35
Insuffisance respiratoire	-	-	3	3	
Pneumothorax traumatique	-	-	2	2	
GASTRO-INTESTINAL					
Gastroentérite	3	1	12	16	3,96
Amblyasie	1	-	1	2	
Abdomen aigu chirurgical (appendicite, péritonite,...)	-	1	14	15	3,71
Ulcère	-	-	3	3	
Cancer (foie, pancréas,...)	-	-	2	2	
Cholangite	-	-	6	6	
Intoxication alimentaire	-	-	1	1	
URO NEPHRO					
Infection urinaire	-	3	6	9	
Circuncision (phimosis)	-	2	-	2	
Synd-néphrotique/glomérulonéphrite	-	-	5	5	
Orchite	-	-	1	1	
GYNECO-OBSTETRIQUE					
Hémo-métrorragies	-	-	5	5	
Endométrite/fièvres puerpérales	-	-	5	5	
Curetages	-	-	10	10	2,48
Césarienne	-	-	1	1	
Hystérectomie	-	-	1	1	
Cancer du sein	-	-	1	1	
Toxémie gravidique	-	-	1	1	
Dystocie/Extraction d'enfant mort	-	-	3	3	
NEURO					
Epilepsie	1	-	2	3	
Hystérie - maladies mentales	-	1	2	3	
Accident vasculaire cérébral	-	-	7	7	
Méningite - encéphalite	2	1	2	5	
Trauma crânien	2	2	2	6	
Paraplégie	-	-	3	3	

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Suite

	Enfants	Jeunes	Adultes	Totaux	%
<b>DERMATO</b>					
Problèmes infectieux	2	7	16	25	6,19
Engelures	-	-	2	2	
Intervention bec de lièvre	-	4	-	4	
Brûlures	2	2	-	4	
Lyell - autres allergies	-	-	2	2	
Cancer cutané	-	-	1	1	
<b>OSTEO-ARTICULAIRE</b>					
Ostéomyélite, arthrite, pyomyosite	-	18	16	34	8,42
Trauma, plaies, gangrène (dont les amputations)	-	2	27	29	7,18
Sciatique paralysante	-	-	1	1	
<b>MALADIES INFECTIEUSES</b>					
Tétanos	-	-	1	1	
Diphthérie	-	1	-	1	
Coqueluche	2	1	-	3	
Paludisme	-	1	5	6	
Hépatite virale	-	1	1	2	
Typhoïde	-	-	1	1	
Autres fièvres	2	6	3	11	2,72
Tuberculose	2	3	20	25	6,19
<b>ANEMIE</b>	-	-	4	4	
<b>BASSEDOW</b>	-	-	1	1	
<b>MALNUTRITION</b>	8	2	-	10	2,48
<b>DESHYDRATATION AIGUE</b>	9	-	-	9	

SUGGESTIONS

Il serait intéressant à partir de toutes les données recueillies de réaliser deux choses différentes (en s'inspirant du dossier, rapport de Mission) :

ANNEX FIFTEEN

BRIEFING PAPER

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BRIEFING PAPER  
HEALTH SECTOR SUPPORT PROJECT

JULY 15, 1988

I. INTRODUCTION:

- Cooperative Agreement signed with MSH Sept. 22, 1986
- Actual implementation begun February, 1987
- MSH is a nonprofit medical consulting firm with considerable preinvasion Afghan experience
- MSH staff:
  - 6 expatriates - team leader plus management, training, field operations, procurement/public health, and financial management advisors.
  - 6 senior Afghan and Pak advisors
  - 110 Afghan/Pakistani employees
- Funding - currently \$15,000,000 obligated. An additional \$8.1 million anticipated in FY 89.

II. Program Objectives

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

III. Accomplishments to date

- The Alliance Health Committee (AHC) has been established with five parties actively participating. Seven departments are staffed and functioning: Administration and Finance, Medical Services, Logistics, Training, Preventive Medicine, Medical Sub-Committee and Monitoring.
- 812 basic health workers graduated from a 3 month course, issued supplies and salaries and deployed inside to establish health posts
- 28 provinces have BHWs assigned to them
- 55 clinics established inside Afghanistan

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- 4 training clinics established
- 2 regional health services established and supported by MSH
- 1 regional BHW training center in Takhar Province established and fully supported
- over 130 tons of supplies have been issued in support of the above facilities with more than 40 tons in 3rd Quarter
- 22 provinces surveyed by MSH monitoring system
- the Alliance Health Committee has been established and has the following departments functioning:
  - Supply supervising movement of supplies inside
  - Medical Services overseeing establishment of facilities
  - Training Center supervising all training, developing curriculae and establishing refresher training for doctors and nurses
  - Preventive Medicine Department has carried out the training of vaccinators, obtained the vaccines and cold chain equipment and is currently deploying vaccinators to four provinces for pilot immunization program
  - Medical Sub-Committee functioning effectively, advising AHC High Council on technical matters and examining and certifying AHC medical personnel
  - Finance & Administration and Monitoring Departments are established but not functioning as effectively as the above

#### IV. NEXT QUARTER

- Pharmaceutical companies have been surveyed for good manufacturing practices and quality control. After six month hiatus, supplies should be rolling in and pace of development of clinics and hospitals will pick up. We expect to establish the following during the Fourth Quarter:
  - 45 new clinics
  - 4 new hospitals
  - 2 new BHW training camps (Sayyaf and Aqani)

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