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**FREEDOM MEDICINE
MONITORING MISSION REPORT**

**Summary Report of FM Clinics Monitored in
Balkh, Bamyan, Faryab, Ghazni, Ghor, Jowzjian, Logar, Samangan and Wardak
Provinces**

January 1991

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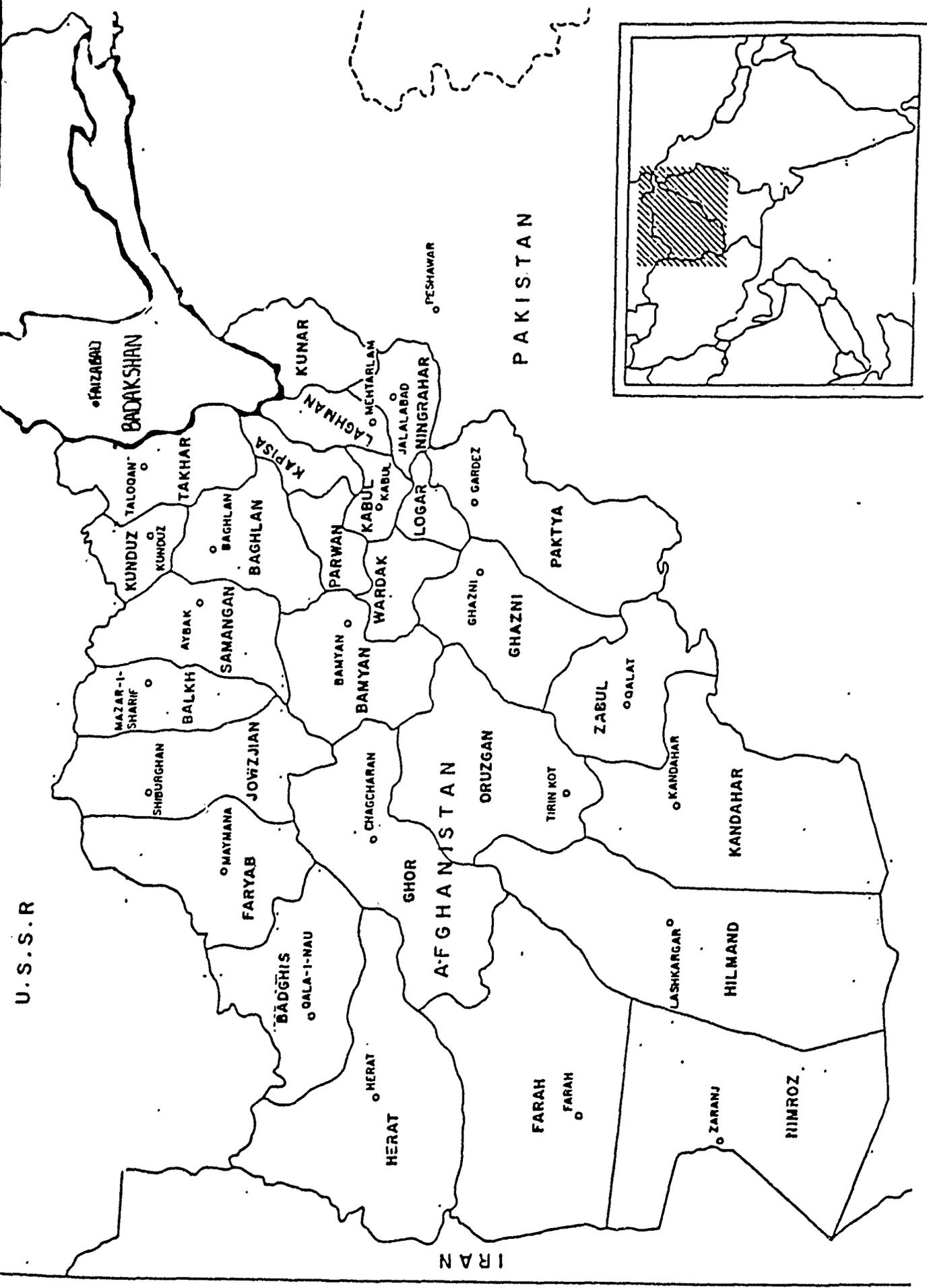
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Special thanks are also given to FM's Special Projects Department, and in particular, Mr. Abdul Bari Badakhshpoor. Without Abdul Bari's insight and knowledge of Afghanistan, this report, as well as the mission itself, could not have been successfully completed. I would also like to thank FM's In-Country Director, Mr. Lynn McFadden, who provided support and encouragement to the Special Projects Department throughout the project.

One further note should be mentioned. This report is based on the knowledge and personal experiences of the FM monitors. The FM Special Projects Department requests the understanding of the reader for any discrepancies in the information provided.

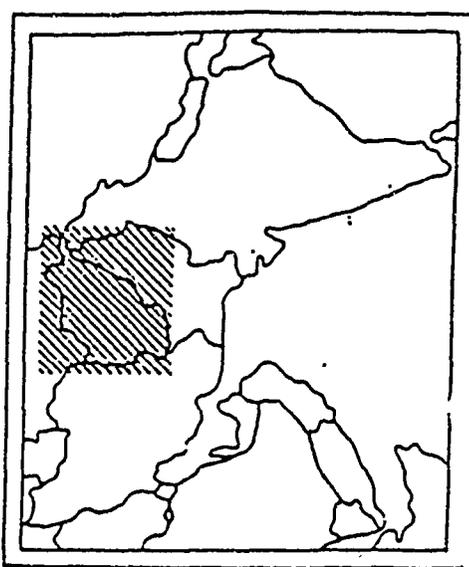
Denise Natali
January 1991



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FREEDOM MEDICINE MONITORING MISSION REPORT

**Balkh, Bamyan, Faryab, Ghazni, Ghor, Jowzjian, Logar, Samangan and Wardak
Provinces**

I. Introduction

A Freedom Medicine (FM) monitoring mission was conducted in northern, central and eastern Afghanistan from August - November 1990. Two FM monitors spent four months verifying and evaluating the activities of FM healthworkers and clinics in nine provinces. The northern areas visited include Balkh, Faryab, Jowzjian and Samangan provinces. On their return trip, the monitors also assessed clinics in the central and eastern provinces of Bamyan, Ghazni, Ghor, Logar and Wardak. The team verified and assessed 29 clinics out of 31 facilities planned to be monitored. A total of 42 healthworkers were evaluated.

This mission had two objectives. For quantitative purposes, the monitoring team verified the presence of FM paramedics and the clinics in which they work. In this regard, the trip was particularly important because monitoring teams have not been able to visit FM clinics in the northern areas during the past two years. This mission was the first formal evaluation of FM's paramedics and their respective clinics in each region. The trip was also designed to assess the quality of the healthcare services provided at each clinic. In doing so, the monitoring team evaluated the provincial healthcare problems, types of services available at each clinic and the nature of referral systems offered at neighboring facilities. The monitors also reviewed the regions' political, economic and security situations. A systemic approach was taken during this mission in order to provide a more comprehensive picture of the healthcare situation in the nine regions monitored. 1

This report summarizes the monitors' findings and provides recommendations for future paramedic and clinic activities. Background discussions of each province are included to provide a brief overview of the political, economic, geographic and security issues that characterize each province. Data analysis is organized into six sections; General Background, Observation of the Facility, Population Served By the Clinic, Equipment and Medical Supplies, Record-Keeping, Area Healthcare Problems/Clinic Services and Transportation/Medical Supply Line. Following the analysis is the monitors' observations and narrative of their four month journey. This section embellishes the analysis by providing first-hand descriptions of the medics and their clinics. It also discusses transportation issues, security problems and logistical constraints and offers a useful account of the difficulties encountered during a trip of this magnitude. Conclusions and recommendations follow and incorporate the findings of the data analysis with monitors' personal observations.

Since FM is transitioning its operations out of Pakistan/Afghanistan, this mission was the final clinic evaluation conducted by FM. All future paramedic/clinic activities will be administered by the Swedish Committee for Afghanistan (SCA) (resupply, debriefing, monitoring, etc.). The findings will be provided to the SCA for future debriefings, database documentation and monitoring

1. Thami, B. - Discussion Paper on Monitoring, Agency Coordinating Body for Afghan Relief (ACBAR), Peshawar, Pakistan, 1989, p.4.

of FM paramedics. They will also be incorporated into a final summary report of FM's activities in Afghanistan during the past six years. Further, the data will be provided to agencies with healthcare facilities in the regions monitored.

Organizations with projects in these areas may find the data useful when planning their own missions. Finally, all information will be provided to the World Health Organization (WHO) for their "WHO Health Database" and "Health Facilities Map" and USAID for further data collection and analysis. It is FM's goal to contribute to the community-wide effort to standardize and streamline healthcare activities in Afghanistan.

II. Methodology

The clinics selected for this mission were chosen on the basis of FM's monitoring needs, the interests of healthcare agencies in Peshawar and the lack of relevant information regarding healthcare problems in northern Afghanistan. For Freedom Medicine, the mission was a first-time evaluation of most of its facilities in Balkh, Faryab, Ghor, Jowzjjan and Samangan province. The trip also served as a second effort to evaluate FM clinics not monitored during the past year. On their return trip to Peshawar, the monitoring team stopped in Ghazni, Logar and Wardak to check the 'non-monitored' clinics of FM's October 1989 mission. Thus, the primary factor for selecting the clinics was to verify and evaluate FM facilities that were not monitored during the past 1-2 years.

Other healthcare agencies in Peshawar also lacked monitoring information of northern Afghanistan. Member organizations of the Coordination of Medical Committees (CMC) expressed an interest and need for more detailed data regarding clinic verification, healthcare problems and facility services. They, too, had not conducted missions in these areas in the past year. There was an apparent need for a monitoring mission to the northern areas. Finally, FM was also concerned about the dearth of practical information of the region. Acquiring specific provincial data from the perspective of experienced, Afghan monitors would benefit those agencies with projects in the areas evaluated.

Accessibility to clinics and travel logistics were significant criteria in scheduling the trip. By starting the mission in August, the SP Director planned to complete the assessment of the far northern areas before winter. Avoiding the affects of snow-covered roads was a primary concern. The schedule was arranged so that the monitors would evaluate Balkh, Faryab, Jowzjjan and Samangan before 1 October. The return trip through Bamyan, Ghazni, Ghor, Logar and Wardak was unlikely to be negatively affected by the change in seasons.

The four-month time frame was based on a geographical and logistical assessment of the area. Before their departure, the monitoring team mapped their route and assessed all possible transportation issues. Clinics located in remote areas or those far removed from the planned route were not included in the mission list (See Appendix A). (FM has a few facilities in Herat that are extremely far from the rest of its clinics. They were omitted from the mission because it would have taken an additional 10-14 days to visit and assess the area.) Planning the travel schedule also meant allotting the monitors time to 'find' certain clinics. It is common for paramedics to relocate their clinics due to political constraints, security issues and/or personal reasons. The SP Director planned an additional two weeks into the monitoring schedule to allot for relocated medics, as well as potential problems that could occur (area fighting, transportation constraints, getting lost, etc).

The Freedom Medicine monitoring questionnaire was compiled from various PVO health surveys provided by The Coordination of Medical Committees (CMC). The questionnaire emphasizes the performance of individual paramedics and their clinics. Some modifications were made since FM's mission in May 1990 to include standard WHO questions on the quality of area healthcare. In comparison to previous missions, this evaluation was more systemic in its approach. Stronger emphasis was placed on the nature and quality of the healthcare system in the entire

region. Further, background information on each province, and the monitors' observations and narrative of the trip were also incorporated into the report.

The questionnaire consists of 46 questions and is divided into 11 parts; 1. Facility Identification Information, 2. Observation of the Facility, 3. Population Served by the Clinic, 4. Equipment, Medicines and Supplies, 5. Recordkeeping, 6. Clinic Services and Programs, 7. Area Health Problems, 8. Community Referral Services, 9. Staff Assistance, 10. Medical Supply Line and 11. Summary Assessment.

The monitoring team evaluated 29 out of 31 facilities planned to be monitored (Excluding all clinics in Parwan-Kapisa and Kabul which could not be accessed due to area fighting). The monitors also completed 16 questionnaires and received ten supporting letters from commanders and local villagers. The team took photographs of several clinics and the surrounding environs (A picture report and original copies of all photographs will be transferred from the FM office to the Coordination of Medical Committees Office in Peshawar).

Two monitors shared the interviewing responsibilities. The method of information gathering included personal observations and interviews with the paramedics or assistants at each clinic. The monitors communicated with local commanders, villagers and patients to solicit additional information regarding paramedics' activities. Where situations were unsafe to travel, the monitors hired local villagers to interview the paramedics and retrieve the necessary information. The team contacted the Special Projects Department in Peshawar throughout their trip. Upon completing the mission, the monitors returned to the FM Peshawar office for debriefing. All information was translated from Dari into English, analyzed and compiled into this written report. Translations from English back into Persian will also be made.

III. Constraints of Data Collection

The monitors visited 29 out of 31 clinics planned to be monitored (This amount excludes 9 clinics in Parwan-Kapisa and Kabul which could not be evaluated due to area fighting.). They successfully verified the presence and activities of 42 FM paramedics. Sixteen questionnaires were completed and ten letters of recommendation were received from area commanders.

Various external factors prevented the monitors from completing questionnaires for each clinic. First, the monitors had a difficult time locating many of the medics. Because this mission was the first of its kind in the region for FM, the planned route and location of clinics was based on outdated information (1988-89). Verifying clinic locations, as well as the paramedics themselves required a great deal of searching and communicating with commanders and villagers. In one situation, the monitors spent eight days attempting to locate two paramedics who relocated their clinic from Jowzjian to Wardak province. As a result, several paramedics/clinics were not verified. Second, security problems negatively affected the monitors' travel options. The monitors were beaten and robbed and threatened by air bombardments from government forces, particularly as they crossed the Laili desert from Jowzjian to Faryab province (see Section VI - Monitors Narrative). Their camera was stolen in Ghazni, leaving them unable to take pictures of several clinics. Third, several

clinics were inaccessible due to poor road conditions. When possible, the monitors hired guides or local villagers to assist them in contacting these clinics. Finally, the monitors were unable to complete questionnaires for clinics whose paramedics were absent during their visit. Facilities without assistants were either closed or guarded by relatives or local commanders. Observation evaluations were made without formal interviews nor reviews of clinic records.

It is important to note that the number of clinics evaluated represents less than one third of the total number of existing FM clinics in Afghanistan (or facilities in which FM paramedics work). There is also a relatively small number of completed questionnaires. Accurate verifications can be made from the data received, however, extensive quantitative analysis is limited. The results derived from the raw data should not be considered for their absolute value, but rather, for relative purposes.

Comparisons to Previous Reports

Comparisons to previous FM monitoring reports should incorporate the differences in the healthcare, politics, security issues and economic structure of each province. The findings of each individual monitoring report are related, in different degrees, to these external factors. For example, FM clinics in eastern Afghanistan (Ghazni, Logar, Paktia) have been monitored several times during the past two years. The medics at these clinics are also debriefed and receive refresher training by FM physicians on a six month basis. Medics in the northern regions, however, have not been monitored since their clinics were established in 1988-89. Further, they are resupplied and debriefed once per year.

Consequently, there has been a greater amount of attention placed on clinics and healthworkers in the eastern and central provinces than their counterparts in the northern areas of Afghanistan. This situation does not indicate a purposeful neglect of the latter. Instead, it reflects the reality of transportation, weather, time and security constraints in the more distant provinces in Afghanistan. For most healthcare agencies in the community, it is easier, quicker and less costly to evaluate healthworkers and their clinics in the regions closest to Peshawar. It is likely, then, that the needs and improvements of clinics in Balkh, Faryab, Jowzjian and Samangan may be greater than facilities in Ghazni, Logar, Paktia, Paktika and Wardak.

IV. BACKGROUND INFORMATION

Balkh Province

Balkh province is located in northern Afghanistan. There are six woleswalis, which include Chan Bolak, Chimtal, Dowlatabad, Nar-e-Shahi, Shalgara and Shortipa. The three alagadaris include Dehdabi, Charkint and Keshindeh. The capital city is Mazar-e-Sharif. The total population of the province is approximately 629,224. It is estimated that 43,500 are refugees currently living in Pakistan or Iran (40,000 live in Pakistan).²

Balkh is bounded by the U.S.S. R. to the north, Samangan province to the east and southeast, and west and southwest by Jowzjian province. There are rivers, deserts and plainlands, but few mountainous regions in Faryab. The Mazar-e-Sharif river, which flows through the central part of Balkh, and the Shadyan Desert, located in the western region, provide geographical diversity and beauty to this province. The northern area of Faryab has an important port, the Bandar-e-Haratan, which is shared between Afghanistan and the Soviet Union. This waterway is strategically significant in its geographical proximity to the Soviet Union. It is used for commercial purposes, government transport and as the location of the Afghani-Soviet pipeline that transports petroleum to the U.S.S.R.

Balkh is one of the most difficult provinces to access from Pakistan. Its far distance north limits the options for travel, particularly during the winter months. The quality of the roads is also poor. Landcruisers cannot traverse the region without interruptions and logistical problems. Pack animals, some local transport and walking are the most dependable and realistic methods for traveling throughout this province. Further, travel from Balkh to Jowzjian involves crossing the Shadyan Desert. The journey, which takes approximately one day, is often threatened by air bombardments by government forces.

The Kabul-Balkh Highway connects Kabul to Balkh City and serves as a major transportation route between the two provinces. It is strategically significant to the commercial interests of the province. This paved, main road is currently open to the population, however, many parts are damaged and insecure due to the presence of landmines and government bombardment. The trip from Kabul to Bamyan Center can take from 8 hours to one full day, depending on weather, road and security conditions.

The majority of the population speak Dari. There are small pockets of Uzbek speaking persons scattered throughout the province.

Balkh houses the famous shrine of the fourth Caliph, the Hazrat Ali Karallahwaju. As part of the Islamic tradition, during the first day of each new year, Muslims from all over the world assemble at the shrine and give tribute to their religion. This historical and religious monument serves as the worshipping center for thousands

2. Eighmy, Thomas H. Ph.D, UNITA/Mapping Service - AFGHANISTAN, Population Estimates by Districts, Office of U.S.A.I.D. Representative for Afghanistan Affairs, Peshawar, Pakistan, Sept. 1990.

All further population statistics are based on this UNITA report.

of Muslims throughout the year.

Balkh plays a significant role in Afghan-Soviet relations. Its proximity to the U.S.S.R makes the province an important buffer zone and region in which persons, goods and services are easily exchanged. The Bandar-e-Haratan not only provides a shared port for commercial and strategic purposes, but also, valuable petroleum resources to the Soviets. Since the beginning of the war in 1979, the Soviets have made futile attempts to move the capital of Afghanistan from Kabul to Balkh City.

Balkh has a diverse political base and is often prone to mujahideen-government bombardments. All regions except the provincial capital of Mazar Sharif are controlled by mujahideen groups. There are three political parties represented in Balkh; JIA, HIA, and HKIA. The Jamiat Islami exerts the major control and is scattered throughout the province. Malawi Alim is the Amir and Attah Mohammad is the commander of JIA. The HIA party controls the Rahmatabad area. The general commander is Malawi Salam. The HKIA does not control any provinces, but has small groups represented in different parts of the region.

The economy is based on agriculture and livestock production. Wheat, rice, cotton and fruit are the main products for export. Food availability is generally good, however, people in the rural areas have faced some food shortages. Small business, particularly carpets, provide another means for employment and trade for the local population. Petroleum is sourced in Balkh, exported to the U.S.S.R., and reimported for use in Afghanistan. In this regard, Balkh plays an important role in providing energy and natural resources to the entire country.

Approximately 34 midlevel healthworkers provide health services in three woleswalis.³ In Mazar-e-Sharif, there is one FM clinic, 2 MSH clinics, 1 MTA clinic, 1 DRA clinic and 1 MSF facility. Char Balaq has a total of two clinics; one administered by MTA and one by MSH. MSH also has one clinic in Deh Bad. In Baba Ewaz-Shulgarah there is 1 FM clinic, 2 MTA clinics and 2 MSH clinics.⁴

3. World Health Organization (WHO) Database, Staff Level by Province, November, 29, 1990
4. UNITA /MAPPING Health Facilities by District - Afghanistan, An Index
To the WHO Health Database, September 1990.

Further background information regarding healthcare facility statistics is based on the WHO/UNITA reports.

Bamyan Province

Bamyan province is located in the central region of Afghanistan. There are four woleswalis which include Yakawlang, Panjab, Waras and Kahmard. The province borders Samangan and Jowzjan provinces in the north, Wardak and Parwan province in the east, Ghor province in the west, Oruzgon province in the Southwest and Ghazni province in the southeast. The capital is Bamyan Center. The total population is approximately 317,142. An estimated 15,000 refugees currently live in Iran and 613 live in Pakistan.

Travel to and within Bamyan is relatively non-problematic. There are few paved roads, however, landcruisers and convoys can access the villages. Mountainous regions, winding roads and harsh weather conditions prevent winter travel for vehicles. The Hajigak Pass, which connects Wardak to Bamyan province, is also closed during the winter months. There are mines located around the airport.

The majority of the province (90%) is from the Shi'a sect of Islam. Dari is the main language spoken by all peoples in the province.

Bamyan is the home of the famous Buddhist idol, the Shur-e-Zuhak. This magnificent monument stands 52 meters high and symbolizes the old civilization of the province. It dates back approximately 500 years and provides the province with cultural enrichment and historical significance.

Bamyan is completely free from government control. It is also the first province liberated by the mujahideen three years ago. The Hezb-e-Wahdat-e-Islami Afghanistan party is most strongly represented and mainly found in Bamyan Center. The Nasar party controls the Yawkawlang district and the Shura-e-Itifad and Apah-e-Pasdaran parties are scattered throughout the province. The JIA and HIA parties are not very popular in Bamyan, since the Sunni population is small. Presently, there is no fighting between the mujahideen and government forces.

The economy is weak, with insufficient agricultural production to export and feed the local population. Food shortages are common and the price of food is very high. Due to the mountainous topography, the amount of arable land is minimal. Livestock production and trade are popular means for subsistence. Many people travel to Kabul, Wardak and sometimes Samangan to work in the local bazaars for income generation.

The healthcare situation is good (ample facilities and healthworkers viv-a-vis the population's needs), relative to other provinces in Afghanistan. There are approximately 16 healthfacilities noted in five woleswalis. These include 1 FM clinic, 2 GAC clinics, 1 SCA health center and 1 MSF hospital in Bamyan Center. In Waras there are 6 FM clinics, 1 MTA clinic and 1 SCA/FM health center. Shibar has 1 FM clinic and 1 SCA/FM health center. There is 1 FM and 1 MTA facility in the western region of Yakawlang, 1 FM clinic in the western area of Sayghan and 1 SCA health center in the northwestern region of Kahamard. There are approximately 35 mid-level health workers in Bamyan.

Faryab Province

Faryab province is located in the northwestern region of Afghanistan. It comprises eight woleswalis and five alagadaris. The woleswalis include Andkvoy, Dowlatabad, Pashtun Kot, Qeysar, Shirin Tagab, Darzab, Belcheragh and Meymanah. The alagadaris are Khan-e-Char Bagh, Qorghon, Qaramqol, Kohestan and Almar. The Teeban Turkistan Mountains are located in the central (Meymanah) region of the province and separate Faryab into northern and southern areas. The Dasht-e-Laili desert is also found in Faryab and constitutes approximately 5% of the total land mass.

The province is bounded by the Soviet Union to the north, Jowzjian province to the east, Ghor province to the southeast and Bagdhis province to the west. The total population of Faryab is estimated at 674,002. Of this amount, approximately 8,029 refugees live in Pakistan or Iran.

The official language spoken is Dari. Scattered throughout the province are Uzbaki and Turkmani speaking peoples as well.

Mujahideen groups control various parts of the province and form base camps within the woleswalis. The Jamiat Islami (JIA) party controls six districts, which include Andkhowg, Dawlatabad, Pashtun Kot, Qaisar, Shreen Tagab and Belcheragh. The Hezb Islami (HIA) party controls the district of Darzab. The Harakat Islami (HKIA) party has 2-3 small groups who are represented in several villages. Government forces control the airport and several bazaars in the capital city, Meymanah.

Transportation within Faryab is relatively insecure and difficult. The six-day journey across the Laili desert from Jowzjian to Faryab province is often threatened by air bombardments by government forces. Further, the lack of water in the desert necessitates adequate food and supplies for the difficult journey. The Teerban Turkistan Mountains also pose travel constraints as they are some of the highest mountain ranges in Afghanistan.

The quality of the roads is poor. Faryab is difficult or often impossible to access by standard vehicle. Landcruisers can complete most journeys on the dirt roads. Local travellers access the region via mujahideen convoy, pack animals, some public transportation or by foot. Due to its far distance north, most roads and transportation routes are closed during the winter months.

Faryab has a good agricultural base which relies on both natural and irrigation-based systems for food growth. The main products for export and subsistence include wheat, maize, barley, nuts, almonds and grapes. A variety of natural resources give Faryab the potential to meet its food needs. However, most crops have been destroyed by fires and ruined by the infection of kafashak (locusts) and/or the Sunn pest. Faryab is currently facing severe food shortages due to crop destruction (wheat) caused by these insects. As a result, food is expensive. People mainly eat melons with bread.

According to the WHO Health Facilities database, there are 37 mid-level healthworkers providing health services in three districts. In Mehmanah, there are 2 FM clinics, 1 IMC and 1 SCA facility. Two additional FM clinics are located in Pashtun Kowt. Management Sciences for Health (MSH) has one clinic in Qala and one clinic in Islam Qala. In general, the number of healthcare facilities relative to the population needs is inadequate. One of the specific concerns of healthcare workers in Faryab is the distance from their resupply sources in Peshawar. Most clinics in this area are resupplied on an annual basis (from SCA). Healthcare needs and area problems often go unattended due to the difficulty in accessing the province.

Ghazni Province

Ghazni province is located in eastern Afghanistan. It is bordered by Wardak in the north, Zabul, Oruzgon and Bamyan in the west, Paktia in the east and Paktika in the south. The total population is approximately 770,684. Of this amount, approximately 69,000 are refugees living in Pakistan and Iran (52,000 live in Pakistan). The total land mass is estimated between 23,000 sq. km. (Government 1979) to 32,800 sq. km (Ademec).

Ghazni consists of 8 woleswalis which include, Andar, Ajristan, Jaghatu, Jaghori, Malestan, Moqor, Navor and Qara Bagh. The capital is Ghazni City.

The province is situated within the mountainous Hindu Kush. There are also areas of desert and semi-arid land. In the eastern area is a large open plain, the Band-i-Sardeh lake and an irrigation project. The mountainous area, called the Hazarajat, is in Jaghori, Malistan, Nawor, Qarabagh, Jaghatu and Kwaja Omari.

There is much history in Ghazni province. Ghazni City was once the royal city of the Ghaznavid Empire (994-1160). At its height, it extended from Persia through Afghanistan and Central Asia into Northern India. Relics from this magnificent period can still be found in Ghazni City. Once noted for its appreciation of the arts, Ghazni City houses many of the Ghaznavid excavations at the Islamic court and home of the famous mystical writer, Abdul Majid Majdud. Other important historical sites include the tomb of Sultan Mahmud (998-1030) at Rawza (north of Ghazni City), two tall minarets and one of the most imposing forts in Pakistan. In 1221 AD, the province was captured and destroyed by Genghis Khan. 5

Ghazni's central location and position on the major route through Kabul from the west and south fosters easy travel to and within the province. Busses, convoys, trucks and standard vehicles use this bypass frequently. The distance from Ghazni City to the Wardak border is approximately 27 kilometers and to Moqor in the south is 100 kilometers. The security situation, however, is somewhat insecure. Parts of the road are controlled by the government and there are areas thought to be filled with mines. Mujahideen convoys are often found travelling on this road, as well as the old Kabul-Kandahar highway. Additional routes and a network of roads are also available to travellers. Standard vehicles and landcruisers can access nearly all parts of the region throughout the year.

Three types of people live in the province; Pashtun, Tajks (Dari) and Hazara. The Pashtun tribe is located in Karabagh and Moqor. The Tajiks live in Ghazni City and Jaghatu. The Hazara tribe can be found in Jaghatu, Nahor and other scattered regions of the province. There is currently infighting between the Pashtun and Hazara tribes.

5. Data Collection for Afghan Repatriation Project - UNHCR Background Report Ghazni Province, 15 April 1990, p. 1-4.

Background information from Logar and Wardak provinces are also sourced from the UNHCR report.

Political control of Ghazni is shared among all of the political groups in Afghanistan. The Itihadi Islami and Harakat/Nabi parties are the most powerful groups and are scattered in various areas in Ghazni. There is a provincial shura that meets monthly and includes representatives from the SYF, HILA, NIFA, JIA, HIG and HIK parties. There is another Pashtun shura coordinated with other provinces and Hazara shuras conducted in Jaghori and Malestan. The government controls Ghazni City but has a small power base.

Agriculture forms the main source of economic subsistence. The main crops include wheat, barley and maize. Despite the relatively healthy plots of land, Ghazni suffers from water shortages and crop destruction from the war. Karez supply the majority of water for irrigation. However, due to the lack of proper maintenance and destruction by bombardment, many of the karez are blocked. Consequently, less water is available than planned. The Band-i-Sardeh and the Band-i-Sultan Dams are the sources of two irrigation projects currently being conducted in the province.

Other sources of income generation include small businesses and trade via the numerous local bazaars and city centers in Ghazni.

The availability of healthcare services in Ghazni is high, relative to most provinces in Afghanistan. WHO estimates that 127 mid-level healthworkers are located in 5 woleswalis in Ghazni. Health facilities are ubiquitous throughout the region. Areas with a strong PVO representation include Ghazni City, with 1 GAC clinic, 1 AIME clinic, 3 LAHC facilities, 1 MGM clinic, 1 MSF clinic and 1 FM clinic. In Qarah Bagh there is 1 FM clinic, 2 SCA health centers, 2 AIME clinics, 1 IMC clinic, 3 MSH clinics and 1 MCI clinic. Jaghuri has 1 MSH clinic, 1 MSF clinic, 1 AIME clinic and 2 SCA facilities. Zaneh Khan and Khaja Omari also have facilities sponsored by FM, SCA, IMC and MSH. There are other facilities scattered throughout the region, but in a less densely situated manner. There appears to be a need to maximize the number of clinics and healthworkers according to population needs and area health problems. Efforts should be made to consolidate clinics in order to reduce the overlap in services, particularly in areas where clinics are located within 6 kilometers from each other.

Ghor Province

Ghor province is situated in the western-central region of Afghanistan. It is bordered in the north by Bagdhis, Faryab and Jowzjan provinces, east by Bamyan province, southeast by Oruzgon, south by Helmand, southeast by Farah and west by Herat.

There are five woleswalis, which include Lal-e-Saraganjal, Shahrak, Tolak, Pasaband and Tiwara. The capital of the province is Chukhcharan. The total population of Ghor is approximately 318,379. Approximately 15,000 of the total 15,882 refugees from Ghor are currently living in Iran.

Ghor is a mountainous and rocky region with little arable land. The Dary-e-Ghor river is located alongside the main road from Bamyan into the province. The dirt road into Ghor is the only passable route into the province. Travellers, landcruisers, convoys and pack animals can all be found along this passageway. It is not particularly dangerous, relative to neighboring areas such as Balkh and Faryab.

The majority of people in Ghor are Sunnis (approximately 80%). There are also Hazara tribes from the Sunni sect of Islam scattered throughout the province. The main language spoken is Dari, however there are pockets of Pushtun-speaking tribes found in small numbers.

Chukhcharan is controlled by government forces. The JIA is the most powerful political party in the province. The JIA general commander of southeastern Afghanistan, Ismael Khan, has much influence in Ghor and has given the region JIA support. The HIA and HKIA are also located in Ghor, but with less control than their JIA counterparts. Other Shi'a and Sunni parties are represented in Ghor, but in small numbers.

The region is currently facing food shortages. Many of the economic problems facing the northern areas also plague Ghor. Crop destruction and low productivity characterize the agricultural base of the province.

Education facilities are available in Ghor for both boys and girls (Approximately 18 in Lal Sarjantal area).

There are 40 mid-level health workers estimated in three woleswalis in Ghor (September 1990). In Sar Jantal, there are 2 FM clinics and one H. LEPCO Hospital. In Teyewarah, there are 3 SCA healthcenters, one MCI clinic and one clinic operated by IMC healthworkers. Khwaja Waha Judin has one MSH clinic and one MCI clinic. There appears to be a need for greater healthcare facilities in this province. One of the difficulties in establishing health facilities in Ghor is finding healthcare workers willing to work in the area.

Jowzjian Province

Jowzjian province is located in northern Afghanistan. There are five woleswalis and six alagadaris in this province. The woleswalis include Aqcha, Minkjak, Qaraqin, Sancharak and Saripul. The alagadaris are Balkhab, Kohistan, Kholb, Mardyan, Faizabad and Khanaqah. The capital of the province is Shuberghan. The total population is estimated to be 677,884. Of this amount, approximately 60,000 refugees live in Pakistan and 10,000 live in Iran.

Jowzjian is bounded by the U.S.S.R. to the north, Faryab province to the west, Ghor and Bamyan provinces to the south and Balkh province to the east. A small part of Jowzjian touches Samangan province in the southeast region. The topography of the province is diverse. There are mountainous regions and arable rainlands found throughout the region. Plainlands are found mainly in the northern areas.

Transportation to and within Jowzjian is difficult. The road into the province is rocky, winding and surrounded by mines. There are also various mountains to cross and rivers without bridges to traverse. The presence of government forces in the capital threaten convoys with bombardment and ambushes near the district lines and city centers. Further, due to its far distance north, Jowzjian winters are exceptionally harsh. Roads are covered by snow during the winter months and are inaccessible, even by walking.

The main languages of the province are Dari and Uzbek. Dari is spoken throughout Jowzjian and Uzbek-speaking peoples are found in Sacharak and Aqcha. There are also pockets of Pushtun tribes in Saripul. A small population of Shi'as can also be found in the Balkhab area.

Control of Jowzjian is shared between government and mujahideen forces. The government presently holds Shuberghan. The Najibullah Intelligence Service (KHAD) has a strong influence among the people and often contacts government troops if mujahideen convoys or travellers enter the area. All political parties are represented throughout the province, however, the JIA party is considered the most powerful. The HIA party and HKIA (Harakat Sunni) are solidly represented in various areas. NIFA is also represented in the province. Overall, the political situation is relatively insecure.

The availability of rainlands, as well as irrigation-based projects, provide Jowzjian with a productive agricultural base. The main products for subsistence and export include grapes, melons, fruit, nuts and almonds. Despite this sound base, the people have been facing famine for three years. Agricultural production has been weakened by locusts and destruction of crops from fire. Food is scarce and expensive (It costs approximately 5,000 Afghanis for 1 ser of wheat). The people generally export their fruits and import wheat. There is also a growing dependence upon livestock.

According to the WHO Health Facilities Map (September 1990), there are approximately 21 healthworkers in 4 regions in Jowzjian. The SCA and MTA each have one facility in Khanaga. There is one IMC clinic in Saripul and 2 FM clinics in Balkhab. Sang Charak has 2 SCA healthcenters and 1 FM clinic.

Logar Province

Logar province is situated in eastern Afghanistan. The four woleswalis include Azra, Mohammad Agha, Baraki Barak and Kulangar and the alagadaris are Chakh and Khoshi. Pul-e-Alam is the capital and is located approximately 50 kilometers south of Kabul. The total population is estimated to be 264,973 persons.

Approximately 216,000 of these persons are refugees living in Pakistan. The total landmass is 4,409 square kilometers.

Logar is situated south of Kabul, east of Wardak, north of Ghazni and Paktia and west of Nangahar provinces. Its location between major provincial centers makes Logar easily accessible from Pakistan and within Afghanistan. There are two passes in the northwestern region that connect Logar to Chardeh in Kabul province and Maidan to Wardak. The Kabul-Ghazni highway crosses the province from north to south. Another main road, which runs from Kulangar to Kabul through Logar, allows travellers to access the district centers. Deteriorating dirt roads are common. Vehicles use these roads to access many of the village areas. However, destroyed bridges and the presence of land mines make journeys dangerous and difficult.

The Ahmadzai and the Tajiks are the two main tribal groups in Logar. The Ahmadzai tribe is the largest Pushtun group who can be found in Azro, the Burg, Mohammad Agra, the Dubandi valley of Khoshi and scattered in other provinces. The Stanekzai and Abdur Rahimzai are other Pushtun groups scattered throughout the province. The Tajiks are located in the Khoshi area, Kulangar, Puli Alam, Baraki Rajan and Baraki Barak and in Charkh Center. The Tajiks in Khoshi and Charkh center are both Shi'a and Sunni.

The government forces control the famous Ainak copper mine near Bini Shahrawgan. It is surrounded by approximately 52 posts and in an area heavily populated with anti personnel mines. A seven party shura was formed in 1990 in Logar.

Logar's economy is based on agriculture and trading. The main cash crops are fruit, especially grapes and apples, and vegetables. Other means of supplementing income include horticulture, animal husbandry and trading. Logar has strong potential for agricultural development. Although the province is called 'granary of Afghanistan', it faces some of the most severe farming problems in the country. According to the Agricultural Survey of Afghanistan (SCA), the lack of manpower, water and technical assistance has reduced the yield of fruit orchards by nearly fifty percent. The presence of mines in the fields and orchards and the decreasing number of animals threaten the agricultural productivity and growth of Logar.

Opportunities for trade stem from the business developed from the local bazaars and trade routes. Profitable trade is conducted in the northern area with Kabul, as well as in the region south of Mohammad Agha (Deh Naw bazaar). Other bazaars are available to foster trade and business development.

Logar has a large representation of PVO healthcare facilities. Areas with major PVO clinic support include Baraki, with 1 FM clinic, 4 SCA health centers, 2 SCA/MTA health centers, 1 MSH clinic, 1 IMC clinic and 1 GAC facility. In Mohammad Agha,

there are 5 FM clinics, 6 SCA health centers, 1 MSH clinic, 1 MTA clinic and 1 IMC clinic. Kolangar has 3 MSH clinics and 3 SCA health centers. There are approximately 112 mid level health workers reported to be working in Logar. Based on the clinic/healthworker distribution, there appears to be a need for consolidation of clinics in areas where facilities are less than 6 kilometers apart from each other.

Samangan Province

Samangan province is situated in the northwestern region of Afghanistan. It comprises three woleswalis and three alagadaris. The woleswalis include Dar-e-Soof, Khulm and Rohi Do Ab. The alagadaris are Hazrat, Sultan and Kaldan. The total population of the province is approximately 312,524. WHO estimates indicate that 18,000 refugees from Samangan live in Pakistan and 1,500 have migrated to Iran.

Samangan is bounded by the U.S.S.R. to the north, Bamyan province to the south, Kunduz and Baghlan provinces to the east and Balkh province to the west. One of the most historically noted areas in the province is Takht-e-Rustam. It is named after Rustam, one of the numerous heroes praised in the Shahnama Ferdowsi, the Persian book which provides accounts of individuals who have bravely fought for Afghanistan. Takht-e-Rustam provides Samangan with cultural significance within Afghanistan's history.

From Pakistan, travellers enter Samangan through Bamyan province. The main road from Samangan to Kabul runs through the Salang valley. It is approximately 400 kilometers, although parts have been destroyed from the war. This road is frequented by standard vehicles, commercial trucks and mujahideen convoys. The route is somewhat insecure, due to the presence of mines and government bombardments along parts of the road. There is also another paved road from Baghlan to Samangan. At this time, however, it is under the control of government forces and used for military purposes. Few local travellers use this road.

Transportation in Samangan is also difficult due to its far distance north. Standard vehicles cannot access the dirt roads to the villages, particularly during the winter months. Landcruisers can make most journeys. Common means of local transportation include pack animals, horses and walking. A relatively safe and successful journey in Samangan may entail joining a local convoy or hiring a guide. It takes approximately 4-5 days to cross the province by foot.

Several political parties are represented throughout Samangan. The two most powerful groups are the JIA and HIA parties. The JIA has a larger representation in the province and can be found in Kholm and the southern region near the Balkh border. JIA control of the southern area is affected by the strong influence of the Shura-e-Nezar in Balkh province, which extends to the border area in Samangan. The HIA party is located in the Sarbagh area. The HKIA is also represented, but in small groups and without major control of any one area.

Like its northern counterparts, Samangan's agricultural base has been weakened by the war. The infection of locusts and the Sunn pest have destroyed many crops and created severe food shortages.

There are few health facilities in Samangan relative to the population's needs. WHO estimates indicate that 11 mid level health workers provide health services on Samangan. Freedom Medicine has two paramedics working in one clinic in Kholm. There is also an FM clinic (with one paradecimal) and an MSH clinic in Aibak province. The SCA/MTA has 1 health center and the GAC has 1 clinic in Roye Doab.

Wardak Province

Wardak province is located in central Afghanistan, south-east of Kabul province. It is bordered by Kabul and Logar provinces in the north, Parwan and Bamyan provinces in the north and north-west and Ghazni in the south. The province is divided into five woleswalis and four alagadaris. The woleswalis include Markaz-i-Behsud, Behsud One, Chak-i-Wardak, Sayedabad and Maidan Shahr. The alagadaris are Jalrez, Nerkh, Dai Mirdad and Jaghatu. The capital of the province is Maidan Shahr and Ghazni is the local regional center. The total population of Wardak is approximately 398,911. It is estimated that 17,000 refugees reside in Pakistan and 10,000 live in Iran. The land mass is approximately 9,699 square kilometers.

The Pashtun and Hazara groups are found in Wardak. The Pashtun tribe is mainly located in the southern districts of Jaghatu, Dai Mirdad, Chak, Sayedabad and Maidan. The Hazara group are mainly situated in Jalrez, Behsud One and Markaz-i-Behsud. Other groups, such as the Durranis and Ghaznis, also live in Wardak.

Wardak is important for its proximity to Kabul. There are several transportation routes that make travel to and within Wardak relatively safe and easy. Three major transportation routes pass through Wardak and connect the province with other regions in Afghanistan. The main highway links Kabul with Ghazni and Kandajar. Another paved, central road that passes through Behsud and the Hazarat connects Wardam with Herat. Further, there is a route that crosses north through the Hajigak and links Wardak to Bamyan and the northern provinces.

Several political parties are represented in Wardak. The HIA, Ittehad (Sayaf) and HKIA parties exert the largest influence and control of the area. The HIA and HKIA parties are strong in Maidan Shahr. Influence in this area allows HIA and HKIA representatives to control transportation routes into Wardak from Logar and Pakistan. HIA Commander Turan Amanullah also has good relations with the Hazaras. The Shi'a Hazara parties, including HIM, Shura Ittefaq, S. Pasdaran, Nasr and Niru, are located in the Behsud districts.

The economy is based on agricultural production. The main crops include wheat, corn, barley, rice and cotton. The majority of land (80%) is pasture. Fifteen percent is non-irrigated farming land and approximately five percent of the land (in Maidan Valley) is irrigated and fertile. The overall availability of food is good but very expensive, relative to other provinces in Afghanistan.

The WHO health facilities map reports approximately 207 mid level healthworkers in five provinces in Wardak. Areas with major PVO representation include Sayedabad, Behsud, Jaghatu and Chak-e-Wardak. In Sayedabad, there are 3 FM clinics, 6 SCA health centers, 1 SCA/FM health center, 2 IMC clinics, 3 MSH clinics, 2 LDI clinics and one 10 bed IMC hospital. Behsud lists a total of eight facilities, which include 3 FM clinics, 2 MSH clinics, 1 IMD clinic, 1 IDG clinic and 1 IMC clinic. In Jaghatu there are 3 FM clinics, 1 LDI clinic, 2 SCA health centers, 2 MDM clinics, 2 MSH clinics, 3 Independent facilities and one 15 bed hospital supported by MDM in the district center. Within Chak-e-Wardak, there is 1 SCA/MTA health center, 1 MDM, clinic 2 LDI clinics, 1 LDI hospital and one 15-17 bed hospital supported by the GAC. These include 3 FM clinics, 5 SCA health

centers, 1 MTA provided in other provinces, but in smaller numbers. According to a June 1990 monitoring report by Dr. Sidiquallah Weera, Provincial Health Directorate for Wardak Province, some of the major healthcare problems in Wardak include an uneven distribution of healthcare facilities relative to the population's needs, varying standards of care and training of healthworkers and adequate diagnoses and treatment of diseases.

V. DATA ANALYSIS

1. Observation of the Facility

The monitoring team took photographs of the clinics based on their observations of the interior and exterior of the facilities, water supply, latrines, storage rooms for medicines and garbage disposals. (Because the camera was stolen during the trip, the monitors did not take photographs of all clinics.)

Nine clinics are located within village areas, three are situated in district centers, three are in provincial centers and one clinic is located within a bazaar.

Six clinics were constructed by the paramedics themselves and five were built by political parties and/or local commanders (JIA). Three clinics are located in existing facilities, such as old government or abandoned buildings. In these situations, no construction was conducted. Two clinics operate out of the paramedic's house.

The overall condition of the clinics is adequate. However, several clinics in the northern provinces received poor assessments by the monitors. The most common complaint was improper medicine storage, insufficient space and inadequate clinic maintenance.

The majority of clinics are structurally sound. Eleven facilities reported no war damage*. Three clinics have approximately 50% destruction and two facilities have 25-30% destruction. Seven clinics are comprised of mud, three are cement-stone based, one is composed of mud and wood and five facilities were constructed with a combination of mud, cement-stone and wood.

The clinics have varying numbers of rooms which reflect the number of health workers at each facility. Excluding the kitchen and latrine areas, five clinics have only one room, six clinics have 2-4 rooms and four clinics have 5-6 rooms. One clinic is located in an 8 room government building but the health services are limited to one room. Clinics with only 1-2 rooms are clearly in need of larger space, particularly if there is more than one healthworker at the clinic. The number of rooms should be proportional to the number of healthcare providers at each facility.

Thirteen clinics have no latrine facilities. Three have functioning latrines, however, there are not separate areas for men and women. The need to establish latrines, as well as and separate areas for men and women in each clinic, is particularly important. Facilities that ensure proper hygiene and sanitation (i.e. wash basin, soap) should also be included and maintained.

There are two main power sources utilized by the clinics. Eleven facilities depend upon a generator (2200 kw) for electric power (supported by FM) and five use kerosene lights.

Five clinics rely on a river for their water source. Five facilities use the nearby stream, three depend upon a well and two facilities receive their water supply from a

* In this report, war damage is defined as building destruction incurred after 1979 as a result of area bombardment.

spring. One clinic has access to both a well and a stream. All clinics except one reported that the water is drinkable without boiling. The clinic that boils its water before drinking receives its supply from the local stream.

2. Population Served By Clinic

The estimated total population served by the clinics varies by province. Six clinics provide healthcare to 50,000 or more persons (60 villages), four clinics serve populations of 20,000 - 50,000 (30-50 villages), four serve 5,000 to 10,000 persons (13-25 villages), one facility serves 10,000 - 20,000 (27 villages) and one clinic serves a population under 5,000 (8 villages). As compared to previous population findings, clinics in the northern areas of Faryab, Samangan and Balkh reported serving a much larger number of villages than their counterparts in the eastern and central areas. One possible reason for this difference in population ratios is the lack of health care facilities in the northern regions monitored. Freedom Medicine clinics are among the few facilities available in the more remote villages of Balkh, Faryab, Samangan and Jowzjan. In these areas, the nearest healthcare facility to an FM clinic is approximately 25 kilometers. Because clinics are dispersed, paramedics from these areas are responsible for serving more villages than the healthworkers in areas such as Ghazni, Wardak and Logar.

The findings showed a positive correlation between the number of villages served and the daily patient flows. Clinics that serve smaller village populations also treat a relatively small number of patients per day. Similarly, larger village populations result in greater daily patient flows. (The average for all FM clinics is approximately 25 patients per day). The five clinics that serve 8-26 villages see approximately 8-15 patients per day. Six clinics treat 20-25 patients daily, 2 clinics see 30-35 patients and 3 clinics treat 50 or more patients per day. The average of all patients seen on a daily basis in the 8 provinces is 27. Overall, the average number of patients by gender treated per day is; 11 men, 8 women and 8 children. All clinics indicated that they are able to examine and treat all of the patients that visit their clinics daily.

3. Equipment and Medical Supplies

Medicine storage and clinic management is inadequate in most of the northern clinics. Facilities in Ghazni, Logar and Wardak received good reports. Due to the lack of proper storage space, no clinics utilize a separate storage area for their medicines. Eleven facilities keep their medicines 'somewhere' within the clinic. In three facilities, the medicines are stored in the medic's house. One clinic uses a karaga to store medicines and supplies and one facility depends upon the local JIA warehouse (The latter situation is not by the medic's choice). The manner in which medicines are stored is described as clean and dry. However, based on the clinic pictures, 4-5 clinics have medicines strewn on shelves in the clinics' rooms. In these facilities, there appears to be a general lack of hygiene and proper management of clinic supplies.

The clinics utilize common methods for sterilizing equipment, instruments and dressings. Two facilities boil their instruments and equipment as part of the general sterilization procedures and one uses an autoclave. Thirteen clinics use formal

tablets in addition to either boiling and/or using an autoclave.

Thirteen clinics dispose their medical wastes by burning and burying the wastes in a pit outside of the clinic. Three others toss their garbage and wastes outside of the clinic.

4. Record-Keeping

In every FM clinic monitored, green books are present and used. In fifteen clinics, the paramedics report that they complete their greenbooks after each patient and in one clinic, statistics are entered once every week. The monitors also inquired about the paramedics' knowledge of the greenbooks. When asked, "What is the purpose of the greenbook," 14 paramedics responded, "To chart the evolution of patients and the types of medicines prescribed." An interesting response came from two medics, who answered, "To send the results back to Pakistan."

The nature of this response is indicative of the larger issue regarding greenbooks; accuracy, validity and reliability. Because the method of charting information is subjective, it is a weak source of meaningful statistical analysis. The accuracy of greenbook data is questionable at best. There is no method of determining whether or not the diagnoses made by the paramedics are correct. Therefore, the validity of the treatments prescribed can not be completely determined. Further, based on the summary of green book usage, it is evident that the FM medics do not share a common understanding of proper record keeping. Many healthworkers do not know why they document their activities. Consequently, it is not surprising to find greenbooks completed in one sitting, usually before the medics return to Peshawar for resupply.

This is not to say that the use of greenbooks should be abandoned. Presently, they are the only source of clinic record-keeping. In this sense the books are tools for documenting the medics' activities and area health care problems. Until another, more reliable method of charting patient flows, provincial health problems and diagnosis/treatments is introduced and implemented, there is little choice but to continue to utilize the greenbook data.

5. Healthcare Problems/Clinic Services

The monitors inquired about the nature of the healthcare problems diagnosed in each village over a 3 month period in both summer and winter months. Based on records from June-August 1990, the three most commonly diagnosed healthcare problems in all clinics monitored were diarrhea (average 24 cases per 100), various symptoms (pains, headaches, etc.) (24 cases per 100) and nutritional problems (18 cases per 100). Malaria was diagnosed in 16 of 100 cases during the 1989 summer months.

In the 1989 winter months, the problems most commonly diagnosed were respiratory infections (37 cases per 100), weakness/physical pain (24 cases per 100), and nutritional illnesses, (14 cases per 100). Other illnesses, such as skin and eye infections, as well as OB/GYN problems were continual problems reported by all

clinics. War -related ailments and mine injuries were noted in relatively small numbers.

Further inquiries were made regarding health problems treated in the four weeks prior to the monitors' visit. Based on the greenbook data, the three most commonly treated illnesses during August 1990 were malaria, goiter and Tuberculosis. War-related injuries were noted in small numbers, except for the Balkh region. One clinic in Balkh reported treating 43 war/mine injuries during the month of August and 102 cases from June -August 1990.

Despite the numbers of serious healthcare problems diagnosed and treated, not one paramedic reported having a death occur in the clinic during the months of July and August 1990. Mortality rates are based on the greenbook data and reveal the problem of accuracy and validity of clinic statistics. In this regard, the data relating to area healthcare problems diagnosed and treated should be noted for their relative, rather than absolute values.

There is a limited quantity and quality of health care services administered by the clinics. All 16 clinics work toward preventing and controlling malaria by distributing malaria tablets (The tablets are included in the SCA medicine supply.). Additionally, 13 clinics provide health education services in the form of nutritional counseling. Although one clinic has a trained vaccinator, there are no vaccination programs administered at any clinic. Further, none of the clinics reported having specialized services for women, such as neo-natal tetanus, MCH training, etc.

The paramedics interviewed indicated an interest in providing additional health education services. One of the major hindrances to such activities is the lack of specialized personnel, as well as physical resources (materials, equipment and supplies).

All clinics use referral services for specialized or emergency cases. Nine clinics use a Pakistani hospital, five refer patients to district facilities and two clinics use a combination of the two. Approximately 2-3 patients per week are referred to the facilities indicated.

Fifteen clinics reported having additional health facilities in neighboring districts and/or villages. The distances of the nearest facilities to FM clinics ranged between 5 and 70 kilometers. One clinic reported having no facilities within a 200 kilometer radius.

Fourteen clinics have additional paramedics, healthcare workers and/or assistants working at the clinic. Four facilities have 2 or more FM medics working together in consolidated clinics. Ten clinics have 1-4 assistants working with one paramedic (two of these facilities include nurses and one vaccinator). In one clinic the paramedic is working independently. (Information for this question was not provided by one clinic.) Based on the information provided from the monitoring team, several paramedics working in neighboring villages should be consolidated within one clinic.

Additional healthworkers have proven beneficial to the management of the clinic. Medics' reported that they are able to treat patients and operate their clinics more

effectively with professional assistance than by working alone. Further, healthcare services are provided more consistently in clinics with a sufficient staff than in those without assistants. Several clinics were closed because the medic was in Peshawar for resupply and there were no additional healthworkers at the facilities.

6. Transportation/Medical Supply Line

Medics transport their medicines to their clinics via the Azam Warsak border point. The medics travel by vehicle and pack animal to their clinics. For four clinics in Samangan and Balkh, the average time spent travelling from the border to each facility is 15 days (14 days via bus or convoy and 1 day by animal). Five clinics in Faryab reported a travel time of 30 days. Seven facilities located in the eastern province of Ghazni, Logar and Wardak require a travel time of 3-8 days from the border (Bamyan takes 5-8 days).

Fourteen clinics reported having problems transporting their medicines because the road to Teri Mangel was closed due to government fighting. Two facilities reported having no transportation problems.

The medicines for 13 clinics arrived at the facilities completely intact. Three clinics had a small amount of medicines damaged (between 20-30 boxes) from the trip and or weather conditions (snow).

Monitor's Observations and Narrative of Trip

Balkh, Bamyan, Faryab, Ghazni, Ghor, Jowzjian, Logar, Samangan and Wardak Provinces

August-November 1990

On 9 August 1990 we left FM's office in Peshawar to begin our monitoring mission. After one day we arrived in Paktia province. We remained in the Chahor Yaran area for two nights and one day. At the time of our arrival, there was bombardment by government airforces (Meg 27-which occurred mainly during the night). A government militiaman called Gelam Jam ambushed the road.

We left Paktia and moved to Ghazni province. The weather in Ghazni was beautiful and the mountains and lands were dressed by green bushes, trees and grass. We rested in the Bandi Sardi area, which is under the control of mujahideen forces and one kilometer away from the government post. There was some fighting in this area between the government and mujahideen groups.

We watched men from the Itihadi Islami Party (Sayef) load 15 vehicles with ammunition and head toward Wardak. We followed them. Later on we saw 14 enemy helicopters which began to fire rockets and surround the mujahideen convoy. Heavy fighting took place for several hours. We were in a jeep with 8 mujahideen in the convoy. By the grace of God, we came out safely from danger.

We were disappointed and scared.

We left the area by travelling through several passes, deep valleys, hills, streams and rivers and arrived into the Shaikabad area of Wardak province. Here, we saw many kinds of fruits and orchards. We also learned that the people import their fruits from Kabul. There is good food availability in this area.

We spent one night in Shaikabad and moved towards Durani. There are mainly Dari speakers in this area. There is good food availability here but it is very expensive. For example, one egg cost 80 Afghanis. The people import their fruit from Kabul and other foods from Pakistan.

The Itihadi Islami party is the dominant force in the area. There is occasional fighting and political insecurity.

We stayed in the area for two nights. We then rented two horses for 10,000 Afghanis per day. We travelled 4 hours and arrived in the Hashtro area of Wardak. The area is full of orchards and gardens. Most people in this area speak Pashto, although there are pockets of Hazaras, too. The behavior of the Pashtuns toward us was better than the manner of the Hazaras.

The road was bad and we faced many problems. For example, horses were not available early in the day and the people did not assist us. We entered the Hazara area and we saw a picture of Imam Khomani posted over the slogan of Iran (Not west, not east, Islamic Republic). When we reached the first Hazara check post, a

mujahideen asked for a letter from the Harakat Islami (Shi'a) party.

We presented the letter and answered the mujahideen's questions. He wanted to know whether or not we were Pushtun or Persian. We said we were Afghan and Muslim. The mujahideen took us to a karaga, where we met an old man who seemed disturbed by our arrival. I (Rahman) talked to him for some time and he gradually welcomed us into his area. I told the man that there was another FM monitor waiting outside and that we should invite him in. The man sent two mujahideen for Lawang and brought him into the room for tea. We thanked the man for his kindness and left shortly thereafter.

We left the area and arrived in Jalriz. Jalriz is under the control of the Itihadi Islami party. There were mainly mujahideens from Itihadi Islami who had come from Paghman district. After spending one night in Jalriz we moved to Sia Khak. There was fighting among the mujahideen groups for approximately one hour. We found ourselves in the midst of the conflict and sought shelter in a small canal. We spent one night in Sia Khak and moved to Behsud district.

All of the people in Behsud are Hazara and speak Dari.

The road in Behsud is unpaved and partially destroyed from the war. Food is expensive (one loaf of bread cost 200 Afghanis) and the people suffer economic hardship. The villagers were unfriendly toward us. After a difficult and unpleasant time in Behsud we moved on to Shashpool.

Shashpool is a rocky and mountainous region. There is minimal arable land for agricultural production. A large river crosses through the valley in this area. Food is expensive and it cost 6,400 Afghanis for the two of us to eat for one day. After spending one night in Shashpool, we left in the morning and moved to Do Ab Mekh Zarin in Baghlan province.

In Baghlan, we spent the night at the former palace of ex-king, Zahir Shah. The facility is currently occupied by a mujahideen group who use the karaga for storage. In the morning we moved to Madr, in Bamian province, where we spent the night with Mullah Nasim and Mangal, two HIA commanders. These men are good people and treated us very well. They thanked Freedom Medicine for its service to the Afghan people.

Early in the morning we moved to Samangan province. It took us six hours from the border to reach Dara-e-Yosuf. We spent two nights in Tatar and arrived in Khuram Sarbagh the following day. The Sarbagh area is under the control of the HIA party. The mujahideen from the area welcomed us and expressed their gratitude for the healthcare provided by FM. On 22 August we arrived at M. Hassan and Shir Ahmad's clinic in Samangan province and began our evaluation.

1. M. Hassan FM 10 Shir Ahmad - Paradental

This clinic was the first facility visited during our trip. The clinic is well situated in the middle of Sarbagh village in Samangan province. With the assistance of the local HIA commander, Qazi Attify, the medics are establishing a new facility. They

were recently consolidated and need a new building with more rooms and space to conduct their work. According to commander Attify, the clinic is expected to be a model facility for Sarbagh.

Attify expressed his happiness with the two medics. Because the facility has both a paramedic and a parodontal, the clinic is able to provide two types of services to the population. The villagers and commanders are pleased with this situation.

We spent two nights in Sarbagh village and then moved on to Dara-e- Zundani. The Dara-e-Zundani valley is a beautiful area surrounded by lush trees, streams and natural waterfall. We saw alot of grapes and almonds growing in the region.

The mujahideen and villagers of the area were very friendly toward us. They expressed their satisfaction with Freedom Medicine and the health care provided to the people of Afghanistan.

Government posts are situated within two kilometers from the village center. There are specific areas around the roads and fields in which government troops are located. A large convoy of supplies which had come from the Haratan port on the Afghani/Soviet border became the target of heavy government bombardment. For eight days and nights, we faced the fire of missiles and rockets. We think that the Soviet troops did not know the exact location of the mujahideen groups because most of their bombardments landed in areas populated by civilians. The exchange of fire was intense. The mujahideen finally captured several areas and 60 men escorted us away from this dangerous place. We finally reached the Khulm district, eight days later than planned.

Upon entering Khulm, we noticed that most of the canals, karez and agricultural lands were destroyed. The harvests were nothing more than ashes, apparently burned from the fires and bombings of the war.

We proceeded to A. Manan's clinic.

2. Abdul Manan FM 8

We debriefed Abdul Manan, checked is clinic and took pictures of the facility. The clinic is well situated in the middle of Khubani bazaar and is accessible by the majority of people it serves. The clinic is inside a three story building. The first floor is used for clinic services and the upstairs is Manan's home. The clinic has its own entrance and is separate from the upstairs rooms.

When we arrived at the clinic, there were approximately 30 people waiting to see Manan. The villagers expressed great satisfaction with Manan, who has been working in Samangan province for over two years. Manan had not returned to Peshawar for resupply since graduating from FM 8 in 1988. Approximately one year ago, he ran out of medicines provided by the SCA. Manan went to the bazaar and purchased medicines on his own. He established a fee based on the costs of the medicines and began charging his patients for his services. The fee was only established to compensate for the costs of his medicines. When the commander of the village heard about this activity, he investigated the situation. Like the villagers, he was not pleased with Manan's fees.

When the commander learned that Manan purchased the medicines himself, he allowed the activity to continue. The people also accepted Manan's fee when they realized the situation. They respect him for continuing to provide healthcare to the village. Manan has met the costs for his initial purchases of medicines.

When we visited the clinic, Manan was very surprised. He thought that FM was no longer supporting medics, and did not return to Peshawar based on this rumor. Manan returned to Peshawar after we completed our evaluation of his clinic.

We spent one night with Manan and left for Marmool in Balkh province. We rented two horses for 50,000 Afghanis. The two day trip to Marmool was dangerous and difficult. The road was full of mines and we could not find one village nor hotel along the way. Food is expensive and scarce; it cost 200 Afghanis for one loaf of bread.

Marmool is under the control of the JIA party. The area is secure and the mujahideen displayed good discipline and relations among each other. We rented two horses and a guide for 30,000 Afghanis and headed to the Shadian area. On the way to Shadian, we heard the sound of firing and were approached by three young mujahids from the JIA party. They came rushing from the mountains, screaming, "Who are you?, Where are you going? etc.. After introducing ourselves, the mujahids told us that the area was the former station of Soviet forces and was full of mines. They interrogated the guide and accused him of being a spy for the KGB. They then beat and whipped the guide and took us to a karaga in Rahmatabad.

Along the way we met commander Nadir Awan and Malawi Salam from the HIA party, who controls the area. They took us to their karaga and questioned us intensely. They accused us of being agents for the KGB. After four hours of investigation, we were released by a medic from the SCA. We arrived in Shulgara district of Balkh province at 12 o'clock at night. By the grace of God, we survived another dangerous situation.

Malawi is the Amir and A. Mohd is the general commander of the JIA party in Shulgara. The JIA controls the district. All of the JIA representatives in Balkh are under the order of the Shura-e-Nezar, which is extremely influential in the province. We checked the JIA hospital where four FM medics were trained. We then proceeded to evaluate M. Dawood and Jalaluddin's clinic in Shulgar bazaar.

3. M. Dawood FM 2 Jalaluddin FM 10

M. Dawood and Jalaluddin work in the same clinic in Shulgar bazaar in Balkh province. Before moving to Shulgar, M. Dawood was working with Najibullah FM 2 and A. Sami FM 2, in the Central Hospital of the JIA party in the central district of Balkh. Dawood was under the direct supervision of the hospital's physicians. After several months of training in the hospital, as well as instruction in clinic management, the JIA sent Najibullah and A. Sami to Faizabad district in Jowzjan province, with one nurse and one assistant.

M. Dawood remained in the JIA hospital until Jalaluddin graduated from the FM 10 course in August 1989. Jalaluddin was placed in the JIA hospital and received additional training under the supervision of JIA physicians. After completing this training, Jalaluddin and Dawood, with the assistance of JIA, established their own clinic in Shulgar bazaar.

The two medics operate their clinic independently. The management and activities of the clinic are excellent. Both medics have a good manner with their patients and they are respected by the people they serve. We received strong recommendations from the medics' JIA supervisors, who continue to oversee the activities of both men on a weekly basis.

Although the medics no longer work for the JIA hospital, the JIA keeps their medicines in the hospital's warehouse. The FM medics receive a 'share' of the total amount of medicines on a monthly basis. Both men are unhappy with the JIA's method of dispersing medicines.

After completing our evaluation, we left Balkh and headed toward Jowzjian. It is impossible to travel from Balkh to Jowzjian alone or with a small group of mujahideen. We were constantly disturbed by locals travelling along the way. Fortunately, a delegation of 37 men from the Shura-e-Nezar in Kunduz and Takhar provinces was visiting the region. They were also going to Jowzjian, Samangan, Faryab and Herat to discuss the opportunities for cooperation with the various parties in Afghanistan. We introduced ourselves and explained the purpose of our mission. The convoy accepted us and allowed us to join them on their journey to Jowzjian.

The road to Jowzjian is dangerous and difficult to access. It is rocky, winding and filled with mines. However, the scenery of this part of the journey is beautiful. The region is surrounded by mountains, orchards and green fields. We spent four days in Jowzjian due to security constraints. We think this region is one of the most insecure provinces in Afghanistan. The Najibullah Intelligence Service (KHAD) has strong influence among the people and often contacts the government troops if mujahideen convoys or travellers enter the area. The JIA party is the dominant political party in Jowzjian. Other parties are represented, but in small numbers and with little influence.

Most of the people in Jowzjian are poor and the arable land is insufficient to solve their economic problems. Food is scarce and expensive (It cost 5,000 Afghanis for 1 ser of wheat). The people generally export their fruits and import wheat. The people have been facing famine for nearly three years. Agricultural production has been hindered by poor weather conditions (lack of rain), locusts and destruction of crops from fire. We heard rumors that the Najibullah government distributes money to these people secretly to help them with their troubles.

In Jowzjian, we witnessed brief fighting between the JIA commander Amanullah and government troops. Two militia men were killed in the squirmish. We proceeded to evaluate the FM clinics in Jowzian.

**4. Najibullah FM 2
A. Sami FM 2**

We planned to visit the well known and respected clinic of Najibullah and A. Sami in Jowzjian province. However, the road to the clinic was closed due to mujahideen fighting and the presence of government troops in the area.

We sent a man named Sakhidad to the clinic instead. The facility is located in Alberz Koh, Faizabad district, Jowzjian province. Sakhidad visited the clinic and interviewed and debriefed A. Sami. The commanders of the area, Haji M. Sadiq and Zabit Khan, both confirmed the quality of the medics' work (Supporting letters are provided).

Both medics were previously working in the JIA hospital as part of the JIA welfare project in Shulgar district, Balkh province. They are very experienced in clinic management and their manner of providing healthcare to the people was also very good. Their former supervisors from the JIA hospital provided them with strong recommendations and support.

We did not take pictures of the clinic since we did not visit the facility personally.

5. Gul Abad FM 3

We went to Khoja Archiq to visit Gul Abad's clinic in Saripul district, Jowzjian province. Unfortunately, the government forces captured the region and prevented us from venturing to the clinic. We received our information from the local commanders and people of the area.

According to the villagers, there are no medics nor physicians in the area. We also met with commander Moalim Sadiq from the Itihadi Islami Afghanistan party. He contacted the incharge of the area, commander A. Raof, by radio. A. Raof indicated that he knew Gul Abad, however, he had not seen him since he left the area four years ago. He told us that he thought Abad was in Peshawar.

NOTE: While we were in Wardak province, we were told that G. Abad was working in the area. However, we could not locate him. At this point, we do not know where Abad is working. We suggest that the SCA be informed about this medic and his situation be discussed before his next resupply.

6. M. Ali FM 10

We went to the Balkhab area in Jowzjian province to visit M. Ali's clinic. We spent several days looking for Ali, as well as Gul Abad, but could not find either medic. We asked many people and commanders from various parties about the medics. Commander Natiqi from the HKIA party provided us with a certificate and confirmed our notion that M. Ali was not working in Jowzjian.

We learned that Ali was working in Wardak province. We suggest that this change be made with the SCA and discussed with the medic before his next resupply. Ali should be told that he should inform the SCA before making any changes in his clinic location.

There are no FM clinics in the Balkhab area.

After spending four days and nights in Jowzjian, we left and headed toward Faryab province. Our trip to Faryab was relatively secure because we had 37 armed mujahideen from the Shura-e-Nezar and 60 mujahideen from Jowzjian province accompanying us. There were no paved roads and we had a difficult time crossing the winding, rocky paths on our horses. We traversed the high, Sardora mountains and the Pesta Mazar desert without seeing any bushes, villages, and water. The entire trip from Jowzjian to Faryab took six days. The first village we arrived in was Qurchi. This area is controlled by Mullah Ahmad from the HIA party.

When we entered the village, we saw the people standing in two lines alongside the road to welcome the Shura-e-Nezar delegation. They were holding a picture of commander Masood in their hands and chanting, "Long Live Mahsood, Long Live Afghan's Salahuddin Ayobi." All types of weapons were then fired in the air. When we reached the local karaga, we saw a group of students singing epic poems. A big gathering took place and many commanders and malawis delivered speeches and presented their deepest thanks and wishes to Masood and the Shura-e-Nezar. They said that we all have one goal, one God, one Book (Holy Quran) and one leader (Masood). This welcome was wonderful and enjoyable for us.

We were invited to visit the karaga and home of engineer Naseen, the Amir and general commander of Darzab district. We travelled across sky-scrapered mountains and passed through another desert. There were no trees nor water along the way. Engineer's Naseem's home is two kilometers from government troops and there are occasional clashes between the troops and mujahideen groups. Naseen warned the government troops not to fire nor fight while we were his guests. That night there were no problems nor air bombardments.

We spent three days in Naseen's area. He expressed his gratitude toward FM for the assistance they provide to Afghanistan. He also announced his full support of the Shura-e-Nezar and indicated his backing of more than 500 mujahideens under his command.

We moved with the Shura-e-Nezar convoy toward Belcheragh district in Faryab. The JIA party controls this district. While the landscape is beautiful, we saw things that made us very sad, particularly the severe shortage of food. The people faced famine for the past three years.

We went to Pashton Kot and checked two FM clinics in Hazarjang and Dehandara villages. M. Alim FM 6 works in Hazarjang and Gh. Farooq FM 4 works in Dehandara.

7. A. Alim FM 6

We visited A. Alim's clinic in Hazarjang village, Mian Dara district, Faryab province. The medic was in Peshawar for resupply at the time of our evaluation. We debriefed his assistant, M. Asif, and took pictures of the facility.

The appearance and management of the clinic is unsatisfactory. The inside is unclean. Boxes are scattered throughout the rooms and the medicines and supplies

are improperly stored. Also, the flow of patients appeared to be greater than what the medic (assistant) could handle. Asif told us that while Alim was gone last week, he, too, was also away. Consequently, there was no one at the clinic to treat the patients.

Despite the clinic problems, the people and commander respect Alim. As monitors, (and not patients who receive medicines when they request them) however, we think that the reason the clinic is poorly managed is because the medic is absent too often from his clinic. We suggest that this situation be discussed with the SCA and Alim before his next resupply.

7. Ghulam Farooq FM 4

Ghulam Farooq was present at his clinic in Dehandara, Pashtonkot, Faryab province. We debriefed the medic and took pictures of his clinic.

The appearance and management of the facility is excellent. The JIA party, which controls the majority of Faryab, built Farooq a beautiful clinic with five rooms. The commander of the village told us that there are other medics from the JIA party who also work in the clinic.

The work of Ghulam Farooq is superior. He received high praises from the commander and the people. He appears to be a conscientious and dedicated healthworker.

We met the local JIA commander, Arbab Hafiz who had a large number of mujahideen and people under his command. He expressed his happiness with FM for establishing medical facilities in the area. We spent three days with Hafiz and then moved to the central area of Jamshidi. From this location, we proceeded to check the clinics of Sakhidad and Faiz Mohd.

8. Sakhidad FM 1

We checked the clinic of Sakhidad in Mehmanah district, Faryab province. The medic was in Peshawar for resupply and there was no assistant available to interview. We took pictures of the facility and evaluated the clinic through observation only.

The appearance of the clinic is inadequate. The interior is a mess, and looks as though Sakhidad has not made any repairs in over two years. Doors are broken and the windows and walls are cracked. There is also an insufficient amount of rooms for the patients to wait and be examined.

The people and the commander of the village told us that Sakhidad was also working in another job as a field officer for the Swedish Committee for Afghanistan (SCA)'s agricultural project.

They expressed dissatisfaction with Sakhidad's work. One of the main reasons for the complaints was the continual absence of the medic from his clinic. He is often busy with his agricultural job. Further, he spends approximately five months per year in Peshawar. When he comes to his clinic, he does not provide adequate services to his

patients. We suggest that the SCA be informed about the activities of this man before receiving his next resupply.

10. Faiz Mohd FM 8

We visited Faiz Mohd's clinic in Jamshidi village, which is eight kilometers from Meymanah, the capital of Faryab. Faiz Mohd was not at his clinic. Although the location of the clinic is good, Faiz Mohd has not been available to provide health services in nearly one year. Since that time, the people have been visiting the government hospital in the area.

The people told us that Faiz Mohd was working well in the clinic for approximately one year. However, when he returned to Peshawar for resupply sometime in 1989, he did not come back to the clinic. The commander, S. Allaudin, did not certify the medic's activities. He said that last year, the HIA and HKIA parties stole Faiz Mohd's medicines in the Goka area. Faiz Mohd did not return after that incident.

We also heard that the medic was working with another commander, S. Amir, from the JIA party in Jamshidi village. We checked this rumor but did not find Faiz Mohd.

We then took a picture of the JIA commander Allaudin and received a letter for documentation. The JIA has full control of the area and there are no other political parties represented. We spent three days with Allaudin, who is a calm and simple man. One day we went to see the provincial capital from the top of a hill. Suddenly, government troops began firing nearly captured us. Fortunately, the mujahideen took us away from this dangerous spot and brought us to safety.

Allaudin gave us some armed mujahideen to escort us to Qurchi village through Gurziwan district. We headed toward Almar district in Faryab, which is under the control of two JIA commanders, Allaudin and Arbab Hafiz. We saw only one commander from the HIA party in Qurchi and he enjoyed good relations with the JIA commanders.

The educational system in this area is good. The local commander emphasized education and reconstructing the social structure of the province. We then monitored M. Azam's clinic in Belcheragh district.

11. M. Azam FM 9

We arrived at M. Azam's clinic in Dehmiran village, Belcheragh district, Faryab province. The medic looked exhausted. He had just arrived from a 30 day journey from Peshawar. We interviewed Azam and took pictures of his clinic.

Azam recently changed his party membership from JIA to HIA, because his commander, Qari Asadullah joined the HIA party. As a result of this change, Azam must relocate his clinic. Commander Asadullah promised to establish a new facility for him in the same village.

His previous clinic was built by the JIA party. The location was excellent because it was in the center of the village and easily accessible to most people. The villagers

expressed concern over the change in Azam's party affiliation. They are very pleased with his work but are afraid that his new clinic location will disrupt the quality of his services.

After this evaluation we separated from the Shura-e-Nezar group and proceeded to Bamyan province. We faced much difficulty because in this area it is difficult to rent horses and guides. One guide costs 2,000 Afghanis per hour. We travelled for ten days and spent 30,000 Afghanis on transportation alone. We arrived in Yakawlang district in Bamyan. The Hezb Wahdat-e-Islami Afghanistan control this district.

We spent four days in Yakawlang trying to find a guide and permission to travel from the incharge of the area. We visited and evaluated the clinic of Barat while in Yakawlang. After we received the proper letters, we proceeded to Lal Sarjangal district in Ghor province.

We met Mr. Etimadi, who graduated from the University of Tehran. He was a good man who welcomed us into his home at midnight (He expressed his gratitude for FM and our concern for the depressed people of the area). We spent the night with Etimadi and learned much about the education available for the girls and boys in Ghor. Etimadi has 18 schools himself. We then left him and proceeded to check S. Mir Asghar's clinic in Sarjangal and Gh. Sakhi's clinic in Chugh Charan.

12. S. Mir Asghar FM 9

We checked S. Mir Asghar's clinic in Sarjangal district, Ghor province. The medic was not there because he was in Peshawar for resupply (as indicated by the people). We took pictures of the clinic but could not complete a questionnaire.

The facility is a mobile clinic. Asghar is often gone 3-4 days per week to provide health care services to neighboring villages. The commander promised us that he would not allow Asghar to leave the village anymore and would find a permanent clinic building for him.

The people in Sarjangal are happy with this medic. We received many recommendations from the villagers, as well as from small commanders and the chief of the Wahdat Islami party. We could not meet his commander, S. Nadir Shah, because he was busy fighting with government forces in Chugh Charan district.

13. Ghulam Sakhi FM 8 s/o Ahmad

We visited Ghulam Sakhi's clinic in Chugh Charan district of Ghor province. Sakhi was not at his clinic. We learned that his real name is Ghulam Ali, s/o Ahmad Ali. We spent some time investigating his whereabouts. After talking to commanders and people from the area, we concluded that G. Sakhi did not work in Ghor. We received letters of certification from the commanders verifying the medic's absence.

We received many complaints about Sakhi's absence. The commanders inquired as to why FM/SCA resupplies this medic since he does not provide proper health services to the people.

When we returned to Bamyan province, we received a report that Sakhi was working in the Sarab region, Bariki village, Waras district, Bamyan province. We returned to Etimadi, who transported us via jeep to Panjab district in Bamyan. The JIA party controls this region completely. When we arrived, the people were celebrating the new year, and we participated in the festivities. We then moved toward Waras district to look for Sakhidad and check the six FM clinics in the area.

We went to Sakhidad's village in Bariki and found a very small area surrounded by approximately eight houses. The people of Bariki told us that Sakhidad was in Peshawar for resupply. When we went to the clinic, we were greeted by Sakhidad's mother. She showed us the facility and allowed us to take pictures.

The clinic is in poor condition. There is no equipment, not even a stethoscope nor a BP cuff. The people are also dissatisfied with Sakhi. They told us that he brings very little medicines to his clinic and charges the people for his services. We then met the commander of the area, Gh. Ali Karbaloy, and received a letter from him. He did not recommend Sakhi nor his clinic in the village.

We think that this medic does not take his SCA medicines to his clinic. We suggest that FM/SCA dismiss this man or introduce him to I. Ibrahim's clinic, which is located nearby in Sorkhsang. The SCA should also be made aware of this man's activities before his next resupply.

We then moved toward Waras district and checked 6 FM clinics in the district. Waras is more densely populated than other districts in Bamyan. We noticed that there was a great lack of food in the region, and most people raised livestock for subsistence. The FM medics in the area (except M. Ibrahim FM 2) charged the people for their health services.

14. S. Ibrahim FM 8

This clinic is located in Dehan Rom Chijon village, Waras district, Bamyan province. Ibrahim was present and working in his clinic at the time of our arrival. Ibrahim's clinic has three rooms. There is a small population living around the building who can easily access the clinic.

The people and commanders are pleased with Ibrahim's work. He has a good manner with the people and is able to see and treat everyone who visits his clinic.

We suggest that this medic be consolidated with M. Ibrahim FM 2, who is located in a nearby village. M. Ibrahim FM 8 currently serves only ten homes in his village. Moving him to Ibrahim FM 2's clinic would allow him to continue to serve his current population, as well as neighboring villages in need of health care services.

15. M. Ibrahim FM 2

Ibrahim's clinic is situated in a good area in Surkh Sang village, Waras district, Bamyan province. Surkh Sang is a central location of the village and located nearby the main road into the village. The clinic is easily accessible by local villagers, as well as people from other areas.

Ibrahim recently built a three-room building for his clinic services. The facility is neat and provides Ibrahim with the proper space to store his medicines and supplies.

The people are very happy with this medic. He is always at his clinic and has gained the trust of the village people. We strongly suggest that all FM clinics in Waras district combine and work as a consolidated clinic with Ibrahim FM 2. The clinic is located in a safe and central area. Further, Ibrahim is a landowner in the village and is well respected by the local population.

16. S. Nayim FM 3 s/o S. Hussain

Nayim was not working because he had no medicines available. He does not have a separate facility for his clinic and uses a room in his house to treat patients. The clinic is located in a very small village that serves approximately 8-10 families. We did not see another health facility in the area.

The appearance, management and hygiene of his one-room clinic is very poor. There is an insufficient amount of space for the medic to properly examine patients, store medicines and conduct clinic activities.

We suggest that Nayim consolidate his clinic with M. Ibrahim's facility in Surkhsang village or join S. Akbar FM 3 in Sarab area and establish a new facility.

17. M. Akbar FM 3

Akbar's clinic is located in the Swabi area of Baraki village, Waras district, Bamyan province. The medic was not present at his clinic because he was in Peshawar for resupply. We interviewed his assistant.

Although the clinic is centrally located, it is structurally difficult to locate. The building does not look like a clinic, but rather, an old, run-down building inconspicuously situated in the middle of the village center. The people and the commander indicated their satisfaction with Akbar's work.

We think that Bariki village is too small to justify the existence of Akbar's facility. His services would be more effectively and efficiently utilized if he relocated and worked with M. Ibrahim or M. Nayim FM 3 in Sarab village. This consolidation effort can be positively administered because all three medics are from the same political party. Additionally, the distance between each other's clinic is less than 15 kilometers. Further, M. Nayim and S. Akbar are brothers and work well together.

18. Ghulam Sakhi FM 8 s/o Ahmed Ali

We spent a great deal of time trying to locate Ghulam Sakhi. We went to Dehan Gool area in Ghor province but could not find the medic. We think that his address was improperly listed or that he relocated his clinic. We returned to Bamyan province and checked a clinic believed to be Sakhi's. However, commander Surabi, the in-charge of the area, did not confirm Sakhi's work. Surabi told us that G. Sakhi did not have a clinic in the area.

We did not verify the presence of this medic during our trip.

19. M. Zaman FM 2

We arrived in Surkhojoy village, Waras district, Bamyan province to find M. Zaman working in his clinic. The appearance of his clinic is poor. The rooms are very dirty and there is insufficient space to properly check and treat the patients.

Zaman's conduct with the patients is also unsatisfactory. The people are unhappy with him primarily because he is often absent from his clinic. They said he has a horse and takes trips to other areas, leaving the clinic closed or unattended. The people specifically referred to one example in which a patient came to the clinic and requested syrup. Zaman did not treat the patient but said that he would examine him 'tomorrow'.

Further, while we were assessing Zaman's activities, we were asked (by Zaman) to wait in another room while Zaman finished treating a patient. After five minutes, Zaman called us back into the examining room. We questioned the other patients as to why we were requested to change rooms. They told us that Zaman charged his patients for his services and did not want us to know about his conduct.

We later learned that this medic has two types of medicines; one set from the SCA and another set purchased from the village bazaar. We asked Zaman why he bought his medicines and he said he needed (wanted) the money and did not care what FM thought about his actions.

The people are displeased with his fees.

We suggest that this situation be brought to the attention of the SCA and discussed with the Zaman during his next debriefing and resupply. We also suggest that his clinic be consolidated with M. Ibrahim FM 2 or with M. Najim and S. Akbar FM 3. Zaman's clinic only serves nine families and it would be more efficient and effective use of his services to combine his activities with neighboring clinics.

20. M. Akbar Paradental

M. Akbar's clinic is located in Bamyan Center, Bamyan province. Akbar was not at his clinic because he was in Peshawar for resupply. We took pictures of the clinic and examined the building through observation only.

The clinic facility is in an old government building. There are 8 rooms in this large facility but Akbar only uses one room. Although the location of the clinic is good, the facility needs to be repaired. Windows and walls are cracked and the doors are without hinges.

The commander and the people gave Akbar good recommendations. He is well respected in his area.

We suggest that Akbar be consolidated with A. Nabi in Tajik village or that A. Nabi relocate to Bamyan Center. If A. Nabi moves to Bamyan, a new facility should be established for the two medics.

21. A. Nabi FM 7

A. Nabi's clinic is located on the outskirts of Tajik village, approximately four kilometers away from S. Akbar's clinic in Bamyan Center. Nabi was working in his clinic when we arrived. We debriefed the medic and took pictures of his clinic. The clinic is located in a central position within Tajik and is easily accessible by the majority of people it serves. There are approximately 70 households within the villages served by Nabi's clinic.

The appearance and management of the clinic are satisfactory.

The commander and the people are pleased with Nabi's work. He is the only Sunni medic in the area who belongs to the JIA party. We suggest that Akbar be consolidated with A. Nabi at Nabi's clinic in Tajik.

NOTE: With the suggestions provided by the monitors, M. Akbar was consolidated with this medic in Tajik village. The clinic now offers dental services as well as general healthcare.

22. Sarajuddin FM 5 s/o Gul Abat

We met Sarajuddin in Bamyan Center. He does not have a clinic, but rather, conduct his own private business. He said that he was no longer interested in working for FM or the SCA and providing healthcare services. He wanted to go into business for himself. We suggest that the SCA be informed about this man's activities and taken off of the 'active' medic list.

23. Delawar FM 2 Ahmad FM 2

We visited Delawar and Ahmad at their clinic in Shubul sub district, Bamyan province. The medics were working at the clinic and we interviewed both men. The clinic is located inside an old government building. It is well furnished and has most of the supplies and medical equipment available to conduct clinic activities. The appearance and management of the facility seemed satisfactory.

At the time of our visit, the clinic was closed due to problems between the villagers and the local commander. Consequently, we did not see any patients in the clinic. According to the medics, it was likely that the clinic would remain closed for at least another week. Rumors indicated that the people were on strike and decided not to visit the clinic.

We later learned that the people were upset with the medics because they often quarreled with each other and complained to the commander. The commanders and the people are trying to resolve the situation. We suggest that the SCA follow up on these medics when they return for their next resupply.

We spent two days in Bamyan then moved toward Ghazni. On the way, we stopped at Najibullah and M. Ayez's clinics.

24. Najibullah FM 6

We visited Najibullah at his clinic in Zeebagh village, Jalriz district, Wardak province. The location of the clinic is good because it is situated in the center of the village and accessible to most of the people. There are approximately 40 households in Zeebagh and no other health facilities beside Najibullah's clinic.

Najibullah uses a room inside his home as his clinic. The one-room clinic was too small for Najibullah to examine patients. Although he ran out of medicines at the time of our evaluation, it is evident that there is insufficient space to store medicines and supplies in this room.

We were told by the villagers that Najibullah was working well before he ran out of medicines. However, since he was not resupplied during his last visit to Peshawar, he has not provided services to the village.

NOTE: At the time of his last resupply, Najibullah was asked to consolidate his clinic and work with M. Ayez FM 10 in the Narkh of Wardak province. Najibullah's refusal to cooperate with FM and the SCA has kept him from receiving another set of medicines.

25. M. Ayez FM 10

M. Ayez's clinic is located in Tokarak village, Narkh district, Wardak province. M. Ayez was dressed in a white medical coat and was present at his clinic when we arrived. We debriefed him and took pictures of the facility.

The clinic is located in an old government building. The appearance and management of the facility is excellent. Medicines are neatly stored on the shelves and the clinic is well supplied.

The people and commanders are very pleased with the work of M. Ayez. He bought a motorbike and often travels to other villages to treat patients.

26. S. Alim FM 10 s/o A. Qudos

We went to Amarkhil village in Wardak province to visit S. Alim's clinic. We did not locate the medic nor his facility. Due to infighting between the NIFA and Hezb Islami parties, Alim, who is a member of NIFA, was forced to leave the area by Hekmatyr (leader of HIA). Presently, HIA controls Amarkhil village and uses a HIA karaga to store Alim's medicines. There are no commanders from the NIFA party in the area.

The people of Amarkhil told us that the NIFA commanders, Shir Agha and S. Nayem, also relocated and established a base in Jalalabad. Thus, there was no one to provide us with information regarding Alim's work.

We did not verify the presence of this medic during our evaluation.

NOTE: Upon receiving his first set of medicines from the SCA after his FM 10 graduation, Alim went to work in his home village of Amarkhil. When he returned to FM for resupply, he was denied SCA medicines because he wanted to move to Jalalabad and work in a mujahideen camp. The medic went to Jalalabad anyway, but without the support of FM and the SCA.

We wanted to check FM clinics in the Nahor area as well. Unfortunately, on the way to Nahor, three armed men beat and robbed us. They pulled the ring from my finger and fractured my hand. I (Rahman) screamed with pain and Lawang jumped on one of the men. The robbers fired at Lawang but missed. They took us to a deep valley and interrogated us. They accused us of being enemies of the Afghan culture and called us foolish Pashtuns. After torturing us for several hours, they let us go. However, they broke our remaining camera and destroyed many of the records and questionnaires we completed.

The next day we went with other mujahideen and found these men. The commander of the Nasr Itihadi party told us that the area is under the control of the Nadir Tank from the HKI Mohseni party. He gave us 9,000 Afghanis and the husband of his sister-in-law also gave us 35,000 Afghanis to continue.

After this horrible incident, we continued to Ghazni province.

27. M. Rahim 9, M. Zaman 9 and Asadullah FM 9

We visited the consolidated clinic of M. Rahim, M. Zaman and Asadullah in Jarmato village, Jaghato district, Ghazni province. None of the medics were at their clinic. M. Rahim and Asadullah were in Peshawar for resupply. We do not know why M. Zaman was not at the clinic.

The clinic is situated in the Jarmato area and serves a relatively large population. The medics were using an old building as their clinic. They were in the process of establishing a new and larger facility to better accommodate themselves, particularly since they were recently consolidated and needed additional space to work together. FM provided 20,000 Rupees to these men to build another facility.

The medics' work is satisfactory. Their activities were positively confirmed by the people and the commander of the village.

NOTE: Although the commander indicated that all three men were in Peshawar for resupply, M. Zaman was not located in Peshawar by the FM SP Director. Follow up on this medic's whereabouts should be made by the SCA at the time of his next resupply.

28. Asadullah FM 10 and Gh. Raza FM 8

On our return to Peshawar, we visited the clinic of Asadullah and Gh. Raza in Jaghato district, Ghazni province. Asadullah was not at the clinic because he was in Peshawar for resupply. We learned that Raza no longer works inside Afghanistan. We interviewed his assistant, Shahjahan. We were unable to take pictures of the clinic because our camera was stolen in the Nahor area in Ghazni.

The clinic consists of three rooms and is well situated in the center of the district. The main road near the clinic makes the facility easily accessible to most households in the district. The inside of the clinic is clean, well managed and sufficiently furnished.

The commanders and people expressed their satisfaction with both medics.

FM has two other medics, Abdullah, FM 7 and A. Raof FM 10, working in the area. We did not travel to their clinic because we were beaten and robbed on our way. However, people from the village confirmed their work and gave them good recommendations.

Upon completing our evaluation in Ghazni, we moved to Logar province to evaluate the clinic of M. Jan. We faced many problems on our way to Zarghan Shahr. In three situations we found ourselves in the midst of government bombardment and heavy fire. We hid in the nearby stream and travelled two kilometers in the cold water to avoid the fighting.

29. M. Jan FM 7, M. Salim EP 4, M. Yassin EP 3, M. Parwiz FM 6

We visited the consolidated clinic of M. Jan, M. Salim, M. Yassin and M. Parwiz in the Zarghon Shahr area of Logar province. We interviewed M. Jan. M. Yassin and M. Salim were inside the clinic. M. Parwiz was not present because he went to fight with mujahideen forces. Because we did not have a camera, we could not take pictures of the clinic.

The clinic is well furnished and relatively organized. However, there is some improvement needed in clinic management. One medic often leaves work for another medic to complete. As a result, the tasks do not get finished. All three men indicated that they would like to work independently.

We departed from Ghorband on 10 November 1990 and attempted to visit Parwan, Laghman and Kabul provinces. However, due to infighting between mujahideen groups and government forces, we were unable to safely travel to these areas. Local mujahideen warned us not to go to Kabul because the road was closed. We reached Ghorband district in Parwan and found that the road was also closed in the area. Consequently, we did not monitor the medics nor clinics in these provinces.

We then returned to Peshawar and completed our mission on 18 November 1990.

VI. Conclusions and Recommendations

The overall evaluation of the medics was satisfactory. Most medics received positive reports (rated 3.5-4.0 on a scale of 1-5, where 1 is poor and 5 is excellent) from the monitors, as well as from local commanders and villagers. Several of the medics in the northern areas relocated their clinics since the first time they were supplied by FM in 1988-89. Once found, they were positively evaluated. Several medics were not at their clinics because they were in Peshawar for resupply. While some of these situations were accurately checked, other cases did not coincide with FM's Special Projects Department and the SCA. It is important that the whereabouts of the medics be confirmed before their next resupply. Further, those medics who were not at their clinics should provide proper documentation verifying their absences. Discussion about absences and tardiness from clinic responsibilities should be conducted by SCA representatives when the medics return to Peshawar.

The condition and management of the clinics, particularly in the northern areas, needs improvement. The main priority should be to enlarge and improve the appearance of the facilities. Many of the clinics in the areas monitored have 2-3 healthworkers within the facility. Adding more rooms would allow each healthworker to administer services more effectively. Further, adding more space and improving the interior appearance of the clinics are important modifications because they affect proper clinic sanitation and hygiene practices. Examining patients in the same rooms in which they wait, and without special washing facilities, fosters disease and infection.

The need to establish latrines, as well as separate areas for men and women in each clinic, is particularly important. Facilities that ensure proper hygiene and sanitation (i.e. wash basin, soap) should also be included and maintained. Responsibility for these modifications should be made by the paramedics themselves.

Community health service programs and referral systems should be more strongly developed at each clinic. Health education (nutritional counseling, disease prevention) is a cost-efficient and effective means of informing the populations about disease prevention. If possible, medics should secure relevant publications, posters, and written materials in Peshawar to distribute to their patients in Afghanistan. Further, there appears to be a need for specialized services for women, particularly MCH and neo-natal issues.

Greater efforts should also be made to consolidate clinics within 6-10 kilometers from each other. Although the quality of care is reported to be satisfactory, villages with 8-15 households per clinic are too small to justify individual facilities. Paramedics should incorporate their activities in order to provide more specialized, efficient and effective health care to their target populations.

Clinic hygiene appears to be satisfactory. As compared to other clinic reports, the availability and quality of water is above average. Equipment, instruments and dressings are sterilized appropriately. As noted above, additional rooms and latrine facilities are important modifications that could improve clinic hygiene and sanitation.

Record-keeping is conducted solely through the greenbooks. While the accuracy and validity of the greenbook data are questionable as tools for statistical analysis, the books are the only means of documenting paramedic activities and healthcare problems. In this sense, the greenbooks should continue to be used by the paramedics. Medics should be informed about the reason why they completed green books. They should understand the importance of the statistics, why they are used and the proper manner of completing their records.

The transportation of medicines and medics to their clinics is conducted in a timely and efficient manner, given the constraints involved in the resupply process. The majority of the clinics received their last resupply shipment intact. The few problems that resulted in minimal medicine loss were external factors that could not be controlled by FM (i.e. cold weather conditions in the northern areas). The medics all suggested that the medicines be shipped in wooden boxes, as opposed to cardboard.

Further area assessments of healthcare problems should be made, particularly in the northern areas. The difficulty in accessing Faryab, Samangan, Jowzjian and Balkh is understood. However, there is insufficient information and monitoring of the clinics and health services provided in these areas. Due to the travel logistics and constraints involved in evaluating the northern/western clinics, healthcare agencies in Peshawar should coordinate their activities and conduct joint monitoring missions.

At the start of 1991, Freedom Medicine paramedics and their clinics will be transferred to work under the supervision of the SCA. The resupply, debriefing and evaluations will continue in much the same manner as it has been during the past five years. The transition will be a smooth one and non-disruptive to the paramedics' activities. The main difference in the resupply process will be the absence of FM as a facilitator and provider of additional clinic support. The result will be more independent and self-sufficient healthworkers working directly with the SCA.

Freedom Medicine strongly recommends the continuation of clinic consolidation efforts. The priority should be to reduce the imbalance of health facilities via population needs. Maintaining greater efficiency and effectiveness in Afghanistan's health care delivery systems is extremely important. Health care agencies should continue to coordinate the flow of information under one healthcare information system. Organizations such as the WHO, USAID and CMC should be utilized as information resources and facilitators of healthcare standardization.

Paramedic/Clinic List

**Balkh, Bamyan, Faryab, Ghazni, Ghor, Jowzjian, Logar, Samangan and Wardak
Provinces**

August - November 1990 Monitoring Mission

BALKH PROVINCE

1. <u>Dawood FM 2</u>	S. Sakhidad	Shulgar Shulgar	M. Alam M. Alam	JIA
• <u>Jalaluddin FM 10</u>	Egumbirdi	" "	" "	JIA

BAMYAN PROVINCE

2. <u>S. Nayim FM 3</u>	S. Hassan	Waras Swabi	Mohaqiq " "	Shura
3. <u>M. Akbar FM 3</u>	S. M. Hussain	Waras Bariki	Mohaqiq S. Hussain	Shura
4. <u>Barat FM 10</u>	M. Husain	Yakawlang Yakawlang	Mubariz Khalil	HKIA
5. <u>S. Akbar FM 10</u>	S. Abdullah	Center Nayak	Mubariz Khalil	HKIA
6. <u>A. Nabi FM 7</u>	A. Razaq	Center Tajik	A. Amin M. Khan	JIA
7. <u>Delawar FM 2</u>	M. Azim	Sheeber Shubul	Danush Adil	HKIA
• <u>Ahmad FM 2</u>	A. Zamir	" "	" "	HKIA
8. <u>S. Ibrahim FM 8</u>	S. Jafer	Waras D. R. Chijon	Mohaqiq S. Hassan	Shura
9. <u>M. Zaman FM 2</u>	Mohibullah	Waras Surkhojoy	Mohaqiq S. Hassan	Shura
10. <u>M. Ibrahim FM 2</u>	Hassan Ali	Waras Surkh Sang	Qurbandi Nowroz Ali	NIFA
11. <u>Saraju'din FM 5</u>	Gulbat	Center Sargoltopehi	Rasofi Rasofi	HIA

* Paramedics/clinics whose names are underlined have been verified and/or evaluated by the moniotors.

FARYAB PROVINCE

12. <u>M. Azam FM 9</u>	M. Ibrahim	Belcheragh Dehmiran	Ab. Rashid Q. Assadullah	JIA
13. <u>Faiz Mohd FM 8</u>	Nazir Mohd	Mehmanah Jamshidi	Allaudin M. Sadiq	JIA
14. <u>Sakhidad FM 1</u>	Gul Mohd	Mehmanah Tokhilkhil	Hafiz Arbab M. Yosuf	JIA
15. <u>M. Alim FM 6</u>	M. Azim	Mian Dara	S. Fak'ddin M. Yosuf	JIA
16. <u>G. Farooq FM 4</u>	M. Yosuf	Pashtunkot Dehandara	M. Yosuf M. Yosuf	JIA

GHAZNI PROVINCE

17. <u>A. Raof FM 10</u>	Hasanjon	Nahor Joy Now	Arbab Sultan Lalsarjanganl	SHRA
18. <u>Assadullah FM 10</u>	M. Nabi	Jaghato Dowlatkhan	M. Amin M. Amin	HKIA
• <u>Gh. Raza FM 8</u>	M. Jon	" "	" "	HKIA
19. <u>M. Zaman FM 9</u>		Jaghato Jermato	Khalid Khalid	NASR
• <u>M. Rahim FM 9</u>		" "	" "	" "
• <u>Assadullah FM 9</u>		" "	" "	" "
20. <u>Abdullah FM 7</u>	Alijoma	Nahor Garmab	S. Jaghan S. Jaghan	SHRA

GHOR PROVINCE

21. <u>Mir Asghar FM 9</u>	S.M. Hassan	Sarjanganl Joy Now	Nadir Lalsarjanganl	HIA
22. <u>Gh. Sakhi FM 8</u>	Ahmad Ali	Ch. Charan Dehangool	A. Rashid A. Rashid	SHRA

JOWZJIAN PROVINCE

23. <u>M. Ali FM 10 *</u>	Sayef	Sangcharak Balkhab	Natigi Abdullah	HKIA
24. <u>Gul Abad FM 3</u>	Bewarkhan	Saripul Khoja Archiq	M. Sadiq A. Raof	JIA
25. <u>Najibullah FM 2</u>	Narby	Faizabad Alberz Koh	S. Rahman S. Sediq	JIA
• <u>A. Sami FM 2</u>	M. Hassan	" "	" "	JIA

LOGAR PROVINCE

26. <u>M. Jan FM 7</u>	A. Khaliq	Moh'd Agha Zar. Sharh	Dr. Fazbullah	JIA
• <u>M. Salim EP 4</u>	M. Zaman	" "	Asadullah	HIA
• <u>M. Yassin EP 3</u>	M. Nasim	" "	Rahim Atash	HKII
• <u>M. Parwiz FM 6</u>	M. Sharif	" "	Mullah Mohd	HKIA

SAMANGAN PROVINCE

27. <u>M. Hassan FM 10</u>	A. Sabin	Center	Atify Sarbagh	HIA Qazi
<u>S. Ahmad FM 10</u>	Rahmatullah	" "	" "	HIA " "
28. <u>A. Manan FM 6</u>	A. Rahman	Khulm G. Kalandar	Shir Ahmad S. Barhi	JIA

WARDAK PROVINCE

29. <u>M. Ayaz FM 10</u>	Mohm'd Khan	Narkh Tokarak	Nawaz Zabitwali	HIA
30. <u>Najibullah FM 6</u>	Mirjon	Jalriz Zeebagh	Gul Rahman "	HKIA
31. <u>S. Alim FM</u>	A. Qadoos	Wardak Amarkhil	Shir Agha S. Naim	NIFA

* M. Ali FM 10 relocated his clinic from Jowzjian to Wardak province.

CLINIC	# ROOMS	LATRINES	WATER SOURCE	WASTE DISPOSAL
M. Zaman	3	None	Spring/Good	Burn/Bury
A. Nabi	1	None	Stream/Good	Burn/Bury
Barat	1	None	Stream/Good	Toss Outside Clinic
M. Ibrahim	3	None	Well/Good	Burn/Bury
S. Ibrahim	1	None	River/Good	Burn/Bury
S. Nayim	1	None	River/Good	Burn/Bury
S. Akbar	1	None	Stream/Good	Burn/Bury
M. Alim	2	None	Well/Good	Burn/Bury
M. Azam	1	None	River/Good	Toss Outside Clinic
Gh. Farooq	6	Yes	River/Good	Burn/Bury
M. Ayez	3	None	Stream/Bad	Burn/Bury
Dawood	5	None	Stream/Good	Burn/Bury
S. Ahmad	6	Yes	Spring/Good	Burn/Bury
Najibullah	5	None	River/Good	Burn/Bury
M. Jan	4	Yes	Well/Good	Burn/Bury
Gh. Raza	3	None	Well/Stream/Good	Burn/Bury

CLINIC CHARACTERISTICS

CLINIC	PATIENTS/M	W	C	SERVICES	NEAR. FACILITY	STAFF.
M. Zaman	15	4	5	6	Malaria Prevention	SCA 35K 1 Medic, 3 Asst.
A. Nabi	10	5	3	2	Malaria Prevention	IMC 25K 2 Medics
Barat	8	5	2	1	Malaria/Nutrition	N/A N/A
M. Ibrahim	20	10	5	5	Malaria/Nutrition	SCA 16K 1 Medic, 3 Asst.
S. Ibrahim	12	5	5	2	Malaria/Nutrition	FM 20K 1 Medic, 1 Asst.
S. Nayim	12	6	4	2	Malaria/Nutrition	FM 20K 1 Medic
S. Akbar	20	8	8	4	Malaria Prevention	FM 20K 1 Medic, 1 Asst.
M. Alim	25	10	5	10	Malaria/Nutrition	JIA 15K 1 Medic, 3 Asst.
M. Azam	20	10	5	5	Malaria/Nutrition	None 1 Medic, 2 Asst.
Gh. Fairooq	30	10	5	15	Malaria/Nutrition	FM 10K 1 Medic, 4 Asst.
M. Ayez	50	30	10	10	Malaria/Nutrition	SCA 30K 1 Medic, 4 Asst.
Dawood	50	30	20	10	Malaria/Nutrition	JIA 5K 1 Medic, 2 Asst.
S. Ahmad	50	15	10	25	Malaria/Nutrition	GAC 70K 2 Medics, 1 Asst.
Najibullah	25	10	6	9	Malaria/Nutrition	SCA 10K 1 Medic, 1 Asst.
M. Jan	35	15	10	10	Malaria/Nutrition	MSH 12K 4 Medics
Gh. Raza	25	10	10	5	Malaria/Nutrition	FM 16K 2 Medics

LIST OF TERMS AND ACRONYMS

AFGHAN POLITICAL PARTIES

(Sunni Parties)

ANLF	Jabha Najati Islami Afghanistan (Afghan National Liberation Front) /Mojadiddi
HIK	Harakat-i-Inqilab-i-Islami Afghanistan/Nabi Mohammadi
HIA	Hezb-i-Islami/Gulbaddin
HIK	Hezb-i-Islami/Khales
JIA	Jamiat-i-Islami/Rabbani
NIFA	Mahaz-i-Milli/Pir Gailani
SYF	Ittihad-i-Islami/Sayef

(Shi'a Parties)

HIM	Harakat-i-Islami/Mohseni. They are more moderate in their approach and receive a small amount of assistance from the west. They are not supported by Iran.
S. Pasdaran	Separ-i-Pasdaran. They originated in and are supported by Iran.
Nasr	Sazman-i-Nasr. They originated in and are supported by Iran. The leader is Khalil, the former spokesman of the Alliance of Shi'a parties.
Shura Ittefaq	This party originated in Afghanistan and is more moderate in its approach. They are not supported nor recognized by Iran. They receive a small amount of assistance from the west. The main commander is Sayed Jaghlan and the leader is Sayed Ali Beheshti. The most influential members of the Hazarat society originally belonged to this party. However, some have changed party alliances to S. Pasdaran and Nasr.
Mustasafin	They are supported by Iran and are more fundamentalist in their approach. Approximately 100 members of this party can be found in and near Bamyan.
Niru	They are mainly found in Behsud district and are lead by Sayyid Zaher Mohaqeq.

ACRONYMS OF PRIVATE VOLUNTARY ORGANIZATIONS (PVOs)

AMI	Aide Medicale Internationale
ASA	Agricultural Survey of Afghanistan
GAC	German Afghanistan Committee
IMC	International Medical Corps
ISRA	Islamic Relief Agency
LEPCO	Leprosy Control, connected with the Marie Adelaide Leprosy Centre in Karachi, Pakistan
MDM	Medecin du Monde
MSF	Medecins Sans Frontiers
MSH	Management Sciences for Health
MTA	Medical Training for Afghans
NCA	Norwegian Committee for Afghanistan
SCA	Swedish Committee for Afghanistan

TERMS

Alagadari	Administrative unit; sub-district
Amir-i-omum	Recognized leader of the resistance in a specific area
Dasht	Dry plain with limited vegetation
Karez	Network of shallow wells connected by a sub-surface channel
Mowlawi	A person educated in Islamic cultures and teacher of Islam for mullahs
Mullah	A person who has completed enough Islamic studies to take care of a mosque and to lead prayers
Shura	Council
Woleswali	Administrative unit; district

**FREEDOM MEDICINE
MONITORING QUESTIONNAIRE
FOR CLINICS IN AFGHANISTAN**

I. FACILITY IDENTIFICATION INFORMATION

Monitor name	_____	Visit Date	_____
Interviewee	_____	Length of Visit	_____
Facility Name	_____	Date Est.	_____
Province	_____	Comm.	_____
District	_____	Amir	_____
Village	_____	Party	_____

1. Who built and financed the clinic building?

2. Name of nearest well-known place, direction and kilo.

3. Latitude/Longitude (if known)

II. OBSERVATION OF THE FACILITY

4. Please take pictures of the following parts of the clinic:

- a. Front View
- b. Inside - where medicine is store
- c. Latrine
- d. Water Supply
- e. Garbage Disposal

5. In what type of location is the clinic situated ?

- a. Province center
- b. District center
- c. Sub-district center
- d. Village
- e. Outside village
- f. Military camp
- g. Other _____

6. Which facilities and activities are located within 30 minute walk from the clinic?
(Circle those that apply)

- a. School
- b. Bazaar
- c. Pharmacy
- d. Government offices
- e. Mujahideen camp
- f. Agricultural activity
- g. Other _____

7. What type of building is the clinic?

- a. Cement
- b. Stone
- c. Wood-frame
- d. Mud
- e. Cave
- f. Other _____

8. How much war-damage (or other) needs repair ?

- a. None
- b. Windows-doors out
- c. 25% structural-damage
- d. 50% structural damage
- e. 75% structural damage
- f. Other _____

9. What is the electricity source ?

- a. None
- b. Generator (kw)
- c. Powerline from _____
- d. Other _____

10. What is the heat source?

- a. None
- b. Kerosene
- c. Wood
- d. Dung
- e. Electric
- f. Other _____

11. What is the water source?

- a. None
- b. Well
- c. Spring
- d. River
- e. Stream
- f. Karez
- g. Canal
- h. Other _____

12. Is the water from this source(s) available year round? If not, during which seasons is it available?

- a. Yes
- b. No _____

13. What is the distance from the water supply to the clinic?

- a. Less than thirty meters
- b. Between 30 and 100 meters
- c. More than 100 meters

14. How is the water transported to the clinic?

- a. By pipe
- b. Pumped out by hose
- c. Bucket
- d. Other _____

15. The quality of the water is:

- a. Good (Drinkable without sterilization)
- b. Should be boiled

16. Please describe the latrine facilities (Circle all that apply).

- a. None
- b. Yes - functioning
- c. Yes - but not functioning
- d. Separate facilities for men/women
- e. One facility
- f. Other _____

17. How far is the latrine from the water source?

- a. Less than 30 meters
- b. Between 30 and 100 meters
- c. Over 100 meters

18. Are the following rooms located in the clinic? If so, how many? Are there medical supplies, equipment and healthworkers working in these rooms? Please indicate for each.

Functioning Supplies/equip. Healthworker

- a. Examining rooms (M/F) _____
- b. Dispensary _____
- c. Storeroom _____
- e. X Ray Room _____
- f. Laboratory _____
- g. Waiting Rooms (M/F) _____
- h. Teaching area _____
- i. Operating room _____
- j. In-patient
beds/spaces _____

19. What is the total # of rooms in the clinic (excluding kitchen area and latrine) ?

III. POPULATION SERVED BY CLINIC

20. How many villages does the clinic serve? Please name villages and their distances to the clinic.

Village

Distance to clinic

- a. _____
- b. _____
- c. _____
- d. _____

21. What is the estimated population served by the clinic?
- Less than 5,000
 - Between 5,000 and 10,000
 - Between 10,000 and 20,000
 - Between 20,000 and 50,000
 - More than 50,000
22. What is the average number of patients seen per day at the clinic?
- _____
 - Those not seen _____
23. Of the patients seen per day, how many are:
- Male _____
 - Female _____
 - Children (under 5 yrs) _____

IV. EQUIPMENT, MEDICINES AND SUPPLIES

24. Where are medicines stored?
- In clinic
 - In medic's house
 - In pharmacy room
 - In a karaga
 - Other _____
25. What best describes the manner in which medicines are stored ? (Circle those that apply)
- Dirty area (mice, etc.)
 - Dry, clean area
 - Locked
 - Easily accessible
 - Other _____
26. Is an inventory checklist taken and used for counting stock?
Where does it go? Please obtain a sample.
- Yes _____
 - No _____

27. What equipment is present and working in the clinic? If the equipment is not present, leave the space blank. If it is present and functional, put an "X" in the "Good" column. If it is present but not functional, put an "X" in the "Bad" column and explain the problem briefly.

<u>Equipment</u>	<u>Good</u>	<u>Bad</u>	<u>Problem</u>
1. Stethoscope	_____	_____	_____
2. Thermometer	_____	_____	_____
3. BP Cuff	_____	_____	_____
4. Baby scale	_____	_____	_____
5. Oxygen tanks	_____	_____	_____
6. Exam table	_____	_____	_____
7. Anaesthesia machine	_____	_____	_____
8. X-ray equipment	_____	_____	_____
9. Dental equipment	_____	_____	_____
10. Sterilizers	_____	_____	_____
11. Dressing trolley	_____	_____	_____
12. Operating table	_____	_____	_____
13. Amputation instr.	_____	_____	_____
14. External fracture fix. instr.	_____	_____	_____
15. Internal fracture fix. instr.	_____	_____	_____
16. Suction equip. (respir.)	_____	_____	_____
17. Microscope	_____	_____	_____
18. Oscope	_____	_____	_____
19. TB slides(Carbon Fuchsin stain AND either _____ Methylene Blue OR Malachite Green stain)	_____	_____	_____
20. Malaria slide supplies (Giemsa OR Field stain) _____	_____	_____	_____
21. Autoclave	_____	_____	_____
22. Hematocrit/Hemoglobin instr.	_____	_____	_____
23. Suture/needles	_____	_____	_____
24. Vaccine refrig, (type)	_____	_____	_____
25. IV stand	_____	_____	_____
26. Laboratory record book	_____	_____	_____
27. Other _____	_____	_____	_____

28. What form of sterilization method(s) is used for instruments and dressings? (Circle those that apply)

- | | |
|--------------------|--------------------|
| a. Boiling | e. Formal tablets |
| f. Alcohol | g. Savlon |
| b. Autoclave | c. Pressure cooker |
| d. Rinsing w/water | d. Other _____ |

29. How are medical wastes disposed (dressings, syringes)?

- a. Tossed outside the clinic
- b. Burn and bury in pit
- c. Open trash area
- d. Other _____

V. RECORDKEEPING

30. Are green books present in the clinic? If so, are they used by the healthworkers?

- a. Yes present/used
- b. No not used

31. Ask the healthworker why he thinks he is filling out the green book. What is the purpose of the green book?

32. Are other records kept? Please obtain sample forms. (Circle those that apply)

- a. Patient medical records
- b. X-rays
- c. Prescription records
- d. Other _____

VI. CLINIC SERVICES/PROGRAMS

33. Which of the following services does the clinic provide? Briefly describe each program (Indicate workers available, special area in clinic for this service, etc.).

<i>Service</i>	<i>Description of Service</i>
a. Pre/post-natal care	_____
b. Dai Training	_____
c. Well Child, Growth Monitoring	_____
d. Other MCH	_____
e. Immunization	_____
f. Rehabilitation	_____
g. Prostheses	_____
h. Tuberculosis	_____
i. Malaria Control	_____
j. Health training	_____
k. Patient & Community Education	_____
(i.e. Outreach, posters, home visits, training etc.)	

VII. HEALTH PROBLEMS

(When completing the questions in this section, please refer to written records, if possible. Otherwise, get estimates from the most informed healthworker. Indicate source of information)

34. Which of the following common health problems have been diagnosed in the last 100 patients seen? (Indicate summer and winter months separately)

Information Source: Records () Healthworker estimate ()

<u>Health Problem</u>	<u># per 100/Summer</u>	<u># per 100/Winter</u>
a. Diarrheal diseases (dysentery, amoeba)		
b. Respiratory diseases (colds, pneumonia, bronchitis)		
c. Malaria		
d. Eye diseases (conjunctivitis, trachoma)		
e. Skin diseases (excluding leprosy)		
f. Gynecological problems		
g. Nutritional problems		
h. Mine injuries		
i. War injuries (non-mines)		
j. Various symptoms (headaches, weakness, etc.)		
k. Other _____		

35. Which of the following special health problems have you treated, cared for, or diagnosed during the last 4 weeks and/or 3 months?

Information Source: Records () Healthworker estimate ()

<u>Health Problem</u>	<u>Last 4 Weeks</u>	<u>Last 3 Months</u>
Malaria (treated)		
Pregnancy related (cared for)		
Neo-natal tetanus (heard about)		
War injuries(not-mines/treated)		
Mine injuries (treated)		
Tuberculosis		
Measles (children under 5)		
Polio (heard about)		
Leprosy (diagnosed)		
Goiter (diagnosed)		
Other health problems		

36. What are the three most recent causes of death for men, women and children?
Please list the last three deaths that have occurred in your clinic in the past month, the age of the patient and the date of the death.

Information Source: Records () Healthworker estimate ()

	<u>Diagnosis</u>	<u>Age</u>	<u>Date of Death</u>
MEN	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
WOMEN	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
CHILD. (under 5)	_____	_____	_____
	_____	_____	_____
	_____	_____	_____

VIII. REFERRAL SERVICES

37. To whom are difficult cases referred? How many referrals have made made during the past 3 months?

<u>Referral</u>	<u>Aver. # per week</u>	<u>Total# (3 mos)</u>	<u>Name/Location</u>
-----------------	-----------------------------	-----------------------	----------------------

- | | | | |
|----------------------------|-------|-------|-------|
| a. Does not refer cases | | | |
| b. Other village facility | _____ | _____ | _____ |
| c. Other district facility | _____ | _____ | _____ |
| d. Pakistani facility | _____ | _____ | _____ |
| e. Afghan facility | _____ | _____ | _____ |

38. What other health facilities are located in the district? Please state the type of facility, the organization name, the distance from the clinic, and whether or not a fee is charged.

<u>Facility</u>	<u>Organization</u>	<u>Distance</u>	<u>Fee charged</u>
_____	_____	_____	Yes No
_____	_____	_____	Yes No
_____	_____	_____	Yes No

IX. ADDITIONAL STAFF

39. Please provide the following information for each healthworker/ health care provider who works at the clinic (not guards, cleaners, etc.).

<u>Name</u>	<u>S/O</u>	<u>Home (prov/district)</u>	<u>Title</u>	<u>Training (where/# mos)</u>	<u>Amt.Salary (paid by)</u>
1. _____					
2. _____					
3. _____					
4. _____					
5. _____					

X. MEDICAL SUPPLY LINE

40. What method(s) of transportation is used to transport medicines from the Pakistani border to the clinic? How many days does it generally take?

	<u># of days</u>
a. Truck	_____
b. Motorcycle	_____
c. Pack animal	_____
d. Porter	_____
e. Other	_____

41. Medicines leave Pakistan via:

- a. Azam Warsak
- b. Chitral
- c. Miran Shah
- d. Quetta
- e. Teri Mangai
- f. Other _____

42. Were any routes closed? If so, which ones? Why?

43. The medicines arrived at the clinic:

- a. All intact
- b. Some amount was damaged. (Approximate # _____ of total)
- c. Other _____

44. What improvements, if any, can be made in transporting medicines?

EVALUATION SUMMARY

45. Please provide an overall assessment of the healthworkers and the clinic in which they work. Use a scale of 1-5, where 1 is poor, 5 is excellent.

	<u>Poor</u>	<u>Fair</u>	<u>Excellent</u>		
a. Clinic appearance	1	2	3	4	5
b. Clinic cleanliness	1	2	3	4	5
c. Clinic organization/management	1	2	3	4	5
d. Clinic effectiveness	1	2	3	4	5
e. Healthworker's conduct with patients	1	2	3	4	5
f. Healthworker's respect by community					
Comments _____	1	2	3	4	5
_____	1	2	3	4	5
_____	1	2	3	4	5
g. Healthworker's attitude toward work	1	2	3	4	5
h. How cooperative have the healthworkers been?	1	2	3	4	5

46. Please indicate any additional information or problems you encountered during the evaluation.

فریدم مدیسن

سوالات مربوط به تفتیش و بررسی کلینیک های
فریدم مدیسن در داخل افغانستان

*

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۱۷ اپریل ۱۹۹۰

دوم: مشاهده یا ملاحظه کلینیک یا مرکز صحتی

۴. لطفاً از قسمت های متذکره ذیل کلینیک عکس برداری نمائید:

الف. از قسمت پیش روی.

ب. از داخل کلینیک و درجائیکه ادویه ذخیره شده است.

ج. بیت الخلا.

د. منبع یا از جایی که آب تهیه میگردد.

ی. محل جمع آوری اشیای بیکاره.

۵. در کدام یک از مناطق ذیل کلینیک قرار گرفته است؟

ای. مرکز ولایت

بی. مرکز ولسوالی

سی. مرکز علاقتداری

دی. قریه

ای. بیرون از قریه

اف. در کمپ نظامی یا مرکز نظامی مجاهدین

جی. دیگر _____.

۶. کدام یک از اسکانات ذیل در فاصله ۲۰ دقیقه پیاده بدور از کلینیک واقع گردیده است؟ (بدور

آن دایره بکشید):

ای. مکتب

بی. بازار

سی. دواخانه یا دوا فروشی

دی. دواپز دولتی

ای. کمپ یا مرکز مجاهدین

اف. اداره فعالیت های زراعتی

جی. دیگر _____.

اول: معلومات مربوط به مشخعات و شناسائی مرکز صحنی یا کلینیک

اسم مانیتور	_____	تاریخ ملاقات	_____
صاحب دهنده	_____	مدت ملاقات	_____
نام مرکز صحنی یا کلینیک	_____	تاریخ تأسیس	_____
ولایت	_____	قوماندان	_____
ولسوالی	_____	امیر	_____
قریه	_____	تنظیم	_____

۱. چه کسی مصارف تعمیر کلینیک را پرداخته و توسط کی اعمار گردیده است؟

۲. نام ساحه یا محل مشهوری که در نزدیکی کلینیک واقع گردیده، راه کلینیک و مسافه آن به کیلومتر.

۳. موقعیت کلینیک به اساس طول البلد و عرض البلد در نقشه، اگر معلوم باشد.

۷. تعمیر کلینیک از چه ساخته شده است :

ای. سنت

بی. سنگ

سی. چوبی

ای. گلی

اف. سون یا مناره

جی. دیگر _____.

۸. مدمات جنگ چقدر است (یا دیگر) ضرورت دارد تا ترمیم گردد؟

ای. هیچ

بی. کلکین ما-دروازه های بیرونی

سی. ۲۵٪ ساختمان صدمه دیده است

دی. ۵۰٪ ساختمان صدمه دیده است

ای. ۷۵٪ ساختمان صدمه دیده است

اف. دیگر _____.

۹. منبع برق چه است؟

ای. موجود نیست

بی. جنراتور

سی. برق عمومی از _____

دی. دیگر _____.

۱۰. منبع حرارت چه است؟

ای. موجود نیست

بی. تیل خاک یا دیزل

سی. چوب

دی. سرگین

ای. برق

اف. دیگر _____.

۱۱. منبع آب چه است؟

- ای. موجود نیست
بی. چاه
سی. چشمه
دی. دریا
ای. جوی
اف. کاریز
جی. کانال
اچ. دیگر _____

۱۲. آیا در همه اوقات سال آب از این منابع بدست می آید؟ اگر نه، در کدام فصل سال میتوان از این منابع آب را بدست آورد.

- ای. بلی
بی. نی _____

۱۳. منبع آب از کلینیک چندتر فاصله دارد؟

- ای. کمتر از ۲۰ متر
بی. بین ۲۰ و ۱۰۰ متر
سی. زیاده از صد متر

۱۴. آب چگونه به کلینیک انتقال داده میشود؟

- ای. توسط نل
بی. توسط پیپ رابری
سی. سطل
ای. دیگر _____

۱۵. کیفیت آب :

- ای. خوب (بدون تعقیم یا جوش دادن قابل نوشیدن است)
بی. باید جوش داده شود.

۱۶. لطفاً سهولت ها یا امکانات برای رفع حاجت را تشریح نمایید (بدور آنهاى که از آن استفاده بعمل مى آید دایره بکشید).

ای. موجود نیست

بی. موجود و قابل استفاده است

سی. موجود است ولی کار ندهد یا اینکه غیر قابل استفاده است

دی. بیت الخلاى مردانه و زنانه از هم جدا است

ای. مردان و زنان از يك بیت الخلا استفاده مینمایند.

اف. دیگر _____.

۱۷. بیت الخلا از منبع آب چقدر فاصله دارد؟

ای. کمتر از ۳۰ متر

بی. بین ۳۰ و ۱۰۰ متر

سی. زیاده از ۱۰۰ متر.

۱۸. آیا اطاق های ذیل در کلینیک موجود است؟ اگر است، چند اطاق؟ آیا سامان و لوازم طبی، ادویه و غیره در آن موجود بوده و کارمندان صحی در آن کار مینمایند؟ لطفاً هر يك از آنها را معرفی نمائید.

فعال	سامان و لوازم	کارمندان صحی
ای. اطاق های معاینه برای مرد ها و زنان	_____	_____
بی. اطاق توزیع ادویه	_____	_____
سی. اطاق ذخیره	_____	_____
دی. اطاق ایکسری	_____	_____
ای. لابراتور	_____	_____
اف. اطاق انتظار مردانه و زنانه	_____	_____
جی. ساحه تدریس	_____	_____
چ. اطاق عملیات	_____	_____
آی. جای بستر مریضان بستری	_____	_____

۱۹. تعداد مجموعی اطاق های کلینیک (به استثنای ساحه آشپز خانه و بیت الخلا) چند است؟

سوم. جمعیتی که توسط کلینیک خدمت میشود.

۲۰. برای چند تریه کلینیک خدمات صحتی را فراهم مینماید؟ لطفاً نام و فاصله تریه ها را نسبت به کلینیک بنویسید.

تریه	فاصله آن نسبت به کلینیک
ای.	_____
بی.	_____
سی.	_____
دی.	_____

۲۱. نفوس یا جمعیت تخمینی ایکه کلینیک خدمات صحتی را برای آنها فراهم مینماید چقدر است؟

ای. کمتر از ۵۰۰۰

بی. بین ۵۰۰۰ الی ۱۰۰۰۰

سی. بین ۱۰۰۰۰ الی ۲۰۰۰۰

دی. بین ۲۰۰۰۰ الی ۵۰۰۰۰

ای. زیاده از ۵۰۰۰۰۰

۲۲. اوسط تعداد مریضانیکه روزانه در کلینیک دیده میشود چند است؟

ای. _____

بی. آنهائیکه دیده نمیشوند.

۲۲. از مریضانیکه روزانه دیده میشوند:

ای. مرد ها

بی. زنان

سی. اطفال (تحت سنین ۵ سال) _____

چهارم: ادویه، سامان و لوازم

۲۴. ادویه در کجا ذخیره شده است؟

- ای. در کلینیک
- بی. در خانه مدیک
- سی. در اطاق فارسی
- دی. در قرار گاه
- دیگر _____.

۲۵. به چه اوصاف و روشی ادویه ذخیره شده است؟ (بدور طریقه ایکه ادویه ذخیره شده است دایره بکشید).

- ای. در ساحه کشیف (موش ها وغیره)
- بی. در ساحه خشک و پاک
- سی. در اطاق قفل شده
- دی. به آسانی قابل دسترسی
- ای. دیگر _____.

۲۶. آیا کدام چک لست موجودی برای شمارش اشیا واجناس در دیپو موجود است؟ به کجا فرستاده میشود؟ لطفاً يك نمونه آنرا بدست بیاورید.

- ای. _____
- بی. _____

۲۷. چه سامانی در کلینیک موجود بوده و قابل استفاده میباشد؟ اگر سامانی موجود نیست جای آنرا خالی بگذارید. اگر سامان موجود و قابل استفاده است در ستون کلمه ((خوب)) حرف ((ایکس)) را بگذارید. همچنان در ستون کلمه ((بد)) نیز حرف ((ایکس)) را گذاشته و مشکل را بصورت خلاصه توضیح نمایند.

سامان	خوب	بد	مشکل
۱. ستاسکوپ			_____
۲. ترمومتر			_____
۳. آل فشار			_____

شکل	بد	خوب
_____	_____	۴. ترازوی اطفال
_____	_____	۵. تانک اکسیجن
_____	_____	۶. میز معاینه
_____	_____	۷. ماشین انستیزی
_____	_____	۸. سامان ایکسری
_____	_____	۹. سامان دندان
_____	_____	۱۰. ستریلیزر
_____	_____	۱۱. اسباب درسنگ
_____	_____	۱۲. میز عملیات
_____	_____	۱۳. سامان امپوتیشن
_____	_____	۱۴. سامان برای فیکس نمودن شکستگی های بیرونی
_____	_____	۱۵. سامان برای شکستگی های داخلی یا درونی
_____	_____	۱۶. اسباب سکشن (تنفسی)
_____	_____	۱۷. میکروسکوپ
_____	_____	۱۸. اوتوسکوپ
_____	_____	۱۹. سلاید تی بی (ستین کاربن فوکسین و میتالین آبی یا ستین سبز ملکتین)
_____	_____	۲۰. سلاید وسامان ملاریا (جیمیما یا فیلد ستین)
_____	_____	۲۱. اوتوکلو
_____	_____	۲۲. سامان هیماتوکریت ، هیموگلوبین
_____	_____	۲۳. تار و سوزن جراحی
_____	_____	۲۴. یخچال واکسین (نوع)
_____	_____	۲۵. پایه آی ری
_____	_____	۲۶. کتاب ثبت لابراتورا
_____	_____	۲۷. دیگر _____

۲۸. از کدام شکل یا متود های تعمیم بخاطر تعمیم سامان و لوازم استفاده میگردد؟ (بدور آن دایره بکشید).

- | | |
|----------------------------------|------------------|
| ای. جوش دادن | ای. فارمل تابلیت |
| بی. الکھول | اف. سولون |
| سی. اوتوکلو | جی. دیگ بخار |
| دی. شستن یا ریختن آب بالای سامان | اچ. دیگر _____ |

۲۹. اشیای بیکاره طبی (درسنگ، سرنج ها) چطور و در کجا جمع آوری میگردد؟
ای. بیرون کلینیک انداخته میشود
بی. در گودال یا چقوری سوختانده و دفن میگردد
سی. در ساحه باز
دی. دیگر _____.

پنجم: نگهداری اسناد یا اوراق ثبت شده

۳۰. آیا کتاب های سبز در کلینیک حاضر است؟ اگر است، آیا کارمند صمی از آن استفاده مینماید؟

ای. بلی، حاضر است، از آن استفاده میگردد
بی. نی، استفاده نمیگردد.

۳۱. از کارمند صمی پرسیده شود که چرا کتاب سبز را خانه پری مینماید. هدف از خانه پری کتاب سبز چه است؟

۳۲. آیا اسناد یا اوراق دیگر کلینیکی نگهداری میگردد؟ لطفاً يك فارم نمونه آنرا بدست بیاورید. (بدور اسنادیکه از آن استفاده و نگهداری میگردد دایره بکشید).

ای. ریکارد صمی مریضان
بی. ایکسری
سی. ریکارد نسخه ها
دی. دیگر _____.

ششم: پروگرام های خدمات کلینیکی

۲۲. کدام يك از خدمات صحتی ذیل را کلینیک مهیا میسازد؛ بطور خلاصه هر يك را تشریح نمائید (کارمندی را که در مناطق بخصوص برای این وظایف تعیین گردیده اند معرفی نمائید).

خدمات	شرح خدمات
ای. مراقبت قبل و بعد از ولادت	_____
بی. تربیت یا تعلیمات برای دانی	_____
سی. مواظبت اطفال یا صحت اطفال و ارزیابی نموی آنها.	_____
دی. مراقبت های صحتی دیگر	_____
ای. معافیت	_____
اف. احیا سازی یا بحالت اول بر گردانیدن	_____
جی. عضو مصنوعی	_____
اچ. تبرکلوژ	_____
آی. کنترل ملاریا	_____
جی. تعلیمات صحتی	_____
کی. مریض و تعلیمات یا تجمیلات اجتماع	_____

(بطور مثال پوستر هابخاطر تدریس، رفتن به منازل و غیره جهت تدریس مردم.

هفتم: مشکلات یا پرابلم های صحتی

زمانیکه میخواهید این بخش سوالات را تکمیل نمائید، لطفاً به اسناد و ریکارد ها اگر امکان موجود باشد مراجعه نمائید. در غیر آن معلومات را بصورت تخمینی از کارمندی که خویشتر آگاه است بدست بیاورید. منبع معلومات را معرفی نمائید.

۲۴. کدام يك از پرابلم های صمی ذیل كه بیشتر عمومیت دارد در هر ۱۰۰ مریض تشخیص گردیده است؟ (ماه های زمستان و تابستان را جداگانه نشان دهید).

منبع معلومات: - از ریکارد () به اساس تخمین کارمند صمی ()

پرابلم های صمی در ۱۰۰ مریض در تابستان در ۱۰۰ مریض در زمستان

ای. مریضی های مربوط به اسهال

(پیچش، آمیب)

بی. امراض سیستم تنفسی (ریزش،

سینه و بغل، برانکایتس)

سی. ملاریا

دی. امراض چشم (التهاب منجمه، تراخم)

ای. امراض جلدی (به استثنای جذام)

اف. پرابلم های سیستم تناسلی

جی. پرابلم های غذائی

اج. صدمات ناشی از ماین

آی. صدمات ناشی از جنگ (نه ماین)

جی. امراض گوناگون (سر دردی، ضعیفی و غیره)

کی. دیگر _____.

۲۵. کدام يك از پرابلم های خصوصی ذیل را تداوی کرده اید؛ در ۴ هفته و یا در ۲ ماه اخیر وقایه و تشخیص شده است.

منبع معلومات: - از ریکارد () تخمین کارمند صمی ()

پرابلم صمی در ۴ هفته اخیر در ۲ ماه اخیر

ملاریا (تداوی شده است)

پرابلم مربوط به حاملگی (وقایه برای)

تیتانوس در طفل نو زاد (در مورد شنیده شده)

در ۲ ماه اخیر

در ۴ هفته اخیر

پرابلم صحنی

_____	صدمات جنگی (نه ناشی از ماین، تداوی شده است)
_____	صدمات ناشی از ماین (تداوی شده است)
_____	توبرکلوز (تشخیص، تداوی شده است)
_____	سرخکان (اطفال تحت سنین ۵ سال)
_____	فلج (در مورد آن شنیده شده است)
_____	جذام (تشخیص شده است)
_____	جاغور (تشخیص شده است)
_____	پرابلم صحنی دیگر

۲۶. سه علت عمده که سبب مرگ مردان، زنان، و اطفال میگردد چه است؟ لطفاً سه واژه مرگی را که در کلینیک شما در ماه های گذشته واقع شده، نام، سن، و تاریخ مرگ مریض را یادداشت ننمائید.

منبع معلومات: - ریکارد ها () تخمین کارمند صحنی

تاریخ مرگ

سن

تشخیص

مردها

زنها

اطفال تحت سنین ۵ سال

هشتم راجع سازی یا فرستادن کیس های مشکل

۲۷. کیس های مشکل به کجا فرستاده میشود؟ چه تعداد کیس ها در سه ماه گذشته به جای دیگر فرستاده شده اند؟

تعداد کیس	تعداد مجموعی در ۳ ماه	نام و موقعیت	راجع سازی	های راجع شده در هفت
_____	_____	_____	ای. کیس ها به جای فرستاده نمیشود	
_____	_____	_____	بی. به کلینیک یا مرکز صحتی تریه دیگر	
_____	_____	_____	سی. به کلینیک یا مرکز صحتی ولسوالی دیگر	
_____	_____	_____	دی. به کلینیک یا مرکز صحتی پاکستانی	
_____	_____	_____	ای. به کلینیک یا مرکز صحتی دولتی	
_____	_____	_____	اف. دیگر	

۲۸. آیا کدام مرکز صحتی یا کلینیک دیگر در ولسوالی موجود است؟ لطفاً نوعیت، نام ارگانی را که توسط آن تأسیس واکمال میشود، فاصله آن را نسبت به کلینیک بنویسید، و همچنان دریابید که آیا از مردم پول اخذ مینمایند یا خیر؟ خیر؟

اخذ پول	فاصله	ارگان مربوطه	کلینیک یا مرکز صحتی
بلی نی	_____	_____	_____
بلی نی	_____	_____	_____
بلی نی	_____	_____	_____
بلی نی	_____	_____	_____

نهم: کارمندان صحت

۲۹. لطفاً معلومات ذیل را در مورد هر يك از کارمندان صحت فراهم نمائید (کارمندانیکه مواظبت های صحت را فراهم مینمایند نه انضباط، مستخدم وغيره).

اسم	ولد	ولایت، ولسوالی	سمت	در کجا چند ماه	تعلیمات	مبلغ معاش	پرداخت توسط
-----	-----	----------------	-----	----------------	---------	-----------	-------------

۱. _____
۲. _____
۳. _____
۴. _____
۵. _____

دهم: خطوط اکمالاتی صحت

۴۰. از کدام متود های انتقالی جهت انتقال ادویه از سرحد پاکستان به کلینیک استفاده میگردد؟ در مجموع چند روز را در بر میگيرد؟

تعداد روز ها

ای. ترك

بی. موتر سايكل

سی. پشت حیوان

دی. جوالی یا حمل

ای. دیگر _____

۴۱. انتقال ادویه از پاکستان به راه:

ای. اعظم ورسك

بی. چترال

سی. میران شاه

دی. کویته

ای. تری منگل

اف. دیگر _____

۴۲. آیا کدام راه اکمالاتی بسته است؟ اگر است، کدام یک؟ چرا؟

۴۳. ادویه به کلینیک رسیده است :
ای. تماماً بدون کم وکاست یا دست نخورده
بی. یکمقدار آن صدمه دیده است (بصورت اعظمی تعداد _____ مجموعی)
سی. دیگر _____

۴۴. چه اصلاحاتی، اگر کدام اصلاحی در سیستم انتقال ادویه موجود باشد؟

خلاصه ارزیابی

۴۵. لطفاً، تمام ارزیابی های خود را در مورد کارمندان صحنی و کلینیک های که در آنها کار مینمایند فراهم و تکمیل نمائید. از میزان ۱- ۵ استفاده نموده نمبر ۱ نقطه ضعف و نمبر ۵ اجرات عالی را نشان میدهد.

ضعیف	خوب	عالی	
۱	۲	۳	۴
۱	۲	۳	۴
۱	۲	۳	۴
۱	۲	۳	۴
۱	۲	۳	۴
۱	۲	۳	۴
۱	۲	۳	۴
۱	۲	۳	۴
۱	۲	۳	۴
۱	۲	۳	۴
۱	۲	۳	۴
۱	۲	۳	۴
۱	۲	۳	۴
۱	۲	۳	۴

ای. شکل ظاهری کلینیک
 بی. نظافت کلینیک
 سی. نظم و اداره کلینیک
 دی. مئوسریت کلینیک
 ای. روش کارمندان صحنی همراه مریضان

اف. مورد احترام قرار گرفتن کارمند صحنی در اجتماع
 تفصیلات _____

جی. نظر کارمند صحنی در رابطه به کارش
 ایچ. همکاری در بین کارمندان به چه شکل بوده است؟

۴۶. لطفاً، در مجموع اگر به کدام مشکلی درحین ارزیابی برخورد کرده اید توضیح دهید.

پایان

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