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Evaluation of

THE HEALTH SECTOR SUPPORT PROJECT
and
THE PRIVATE VOLUNTARY ORGANIZATION SUPPORT PROJECT

Maternal and Child Health and Immunization Programs

Prepared for

The USAID Mission for Pakistan and Afghanistan

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LIST OF ACRONYMS AND ABBREVIATIONS

ACBAR	Agency Coordinating Body for Afghan Relief
AFO	Afghanistan Field Operations
A.I.D.	Agency for International Development, Washington
AIG	Afghan Interim Government
AOGH	Afghanistan Obstetrics and Gynecology Hospital
ARI	Acute Respiratory Infection
AVICEN	Afghanistan Vaccination and Immunization Center
BHC	Basic Health Center
BHW	Basic Health Worker
CCS	Cold Chain Supervisor
CDD	Control of Diarrheal Diseases
CHC	Comprehensive Health Center
CMCEP	Combined Midlevel Continuing Education Program
DC&A	USAID Data Collection and Analysis Unit
Dai	Afghan traditional birth attendant
EC	European Community
EPI	Expanded Program of Immunization
FHW	Female Health Worker
HCCA	Health Committee of Central Afghanistan
HCCP	Health Committee of Paktya and Paktyka
HSD	Health Services Department/Directorate (MOPH)
HSSP	Health Sector Support Project
IMC	International Medical Corps
IPH	Institute of Public Health (MOPH)
IRC	International Rescue Committee
MCH	Maternal and Child Health
MCHO	Maternal and Child Health Officer
MCI	Mercy Corps International
MIS	Management Information Systems
MMC	Mujahid Emergency Medical Center
MOPH	Ministry of Public Health
MSH	Management Sciences for Health
NGO	Non-Governmental Organization
ORS	Oral Rehydration Salts
PHC	Primary Health Care
PMD	Preventive Medicine Department/Directorate (MOPH)
PVO	Private Voluntary Organization
RHA	Regional Health Administration (i.e., the SCNA, SSWA, HCCA AND HCPP area programs)
RHO	Rural Health Officer
SOW	Statement of Work
SCA	Swedish Committee for Afghanistan
SCNA	Supervisory Council of the North Area
SSWA	South and Southwest Afghanistan
TBA	Traditional Birth Attendant
TB	Tuberculosis
UNICEF	United Nations Children's Fund
UNOCHA	United Nations Office for Coordinating Humanitarian Assistance for Afghanistan
USAID	United States Agency for International Development (Field missions of A.I.D.)
VHS	Volunteer Health Sister
VSF	Vaccine Storage Facility
VSO	Volunteer Service Organization

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EXECUTIVE SUMMARY

Since 1986, the United States Agency for International Development (USAID) has supported health projects from Peshawar and Quetta whose beneficiaries live cross-border in Afghanistan. The Health Sector Support Project (HSSP, 306-0203) is administered by Management Sciences for Health (MSH) and the PVO Support Project (306-0203) administered by three private voluntary organizations (PVOs), International Medical Corps (IMC), Mercy Corps International (MCI) and the International Rescue Committee (IRC). The original purpose of U.S. assistance was to provide emergency medical care inside of Afghanistan. As the situation changed in Afghanistan, the projects were modified so that the purpose became to develop and institutionalize the capabilities of Afghan authorities to operate effective health delivery systems and provide basic health care to Afghans living in Afghanistan. During the last 3 years, attempts were made to increase the delivery of maternal and child health (MCH) services - which includes the expanded program for immunization (EPI) - intended to reach these two groups which had been inadequately addressed.

In March, 1993, the Mission prepared a new strategy document focusing on the most urgent social needs of the country as a statement of how it intends to respond to those needs. The Mission has been made aware that FY 1994 funding levels for all USAID supported activities will be significantly reduced from former levels. From three areas of support outlined in the latest Afghanistan Strategy, health and education are the two selected by the Mission for continued support, presuming continued funding. In health, the focus will be on MCH services provided by female workers and EPI.

The evaluation is to cover only the MCH and EPI components of the four implementing agents, with an emphasis on MSH's experiences. General questions related to all four entities are to be answered, as are questions specific to each entity. Additionally, EPI/MCH/female training programs funded by other donors are to be reviewed as possible alternative strategies. Recommendations are to be made for effective implementation of an EPI and MCH program.

A. Achievements Against Project Objectives - MCH and EPI

- MSH, working with the Institute of Public Health (IPH), has developed training programs, methods of recruiting, and curricula, and has trained and deployed two new categories of female health workers, the mid-level Maternal & Child Health Officer (MCHO, a provider) and the Village Health Sister (VHS), a community health worker. Early assessments of both are promising. Training of both categories is inside Afghanistan.

- Over 450 traditional birth attendants have been upgraded to Female Health Workers (FHWs) in UN-approved birth-related practices and in very basic health and sanitation concepts. This training has improved health status in countries where such can be measured.

- The MSH-sponsored EPI operation is one of the two largest operating cross-border (254 vaccinators working in 101 districts in 24 provinces) with 9 vaccine storage facilities inside and one in Peshawar. It annually targets 212,000 children under 2 and a 198,000 women 5 - 45. About 60 percent of the children's target and 23 - 43 percent of the female target is reached annually.

- MSH's MCH and EPI activities largely are administered through Regional Health Administrations and increasingly with full knowledge and agreement with the Afghanistan MOPH.

- The IRC provided grants to two MCH activities, the Afghan Ob/GYN Hospital while it was in Peshawar (now funded by the Norwegians in Jalalabad) and the Mujahid Medical Center (MMC) in Jalalabad. Both activities are providing high quality MCH, with innovations by the MMC.

- Three of six proposed MCH clinics were established by MCI in the south, but only two female providers remain. Proposed training of MCHOs was not approved by USAID because of the phase down. MCI got other funding for EPI activities which USAID had offered to fund.

- Because of diminished USAID funding, IMC EPI activities in 26 districts were discontinued in December, 1992. The plan was that another implementor would pick up those teams, but not all were picked up.

B. Major Constraints to Project Implementation

- By far the greatest impairment has been the prohibitions or restrictions against official American presence inside.

- Monitoring is largely "head-count", with more informative and important technical monitoring insufficiently carried out for reliable quality control.

- The absence of a "friendly" central government and associated counterparts has hampered indigenous imprimatur and coordination of donor activities. Coordination of EPI activities was hampered.

- The phase-out requirement has stopped significant momentum in both EPI and MCH activities.

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- Traditional and cultural practices which have restricted access to health care for females and children have slowed, but not sidetracked, the pace of implementation.

- A constraint related to the foregoing is the great difficulty in recruiting female trainers and health professional trainees. This may become a greater problem should additional MCH training be carried out.

- Constraints related to security, personal and property, undoubtedly have affected individual performances inside. Periodic USAID-imposed bans because of security problems have delayed implementation of both MCH and EPI activities, particularly the 6 month ban in latter 1991.

- Unexpectedly severe cuts in funding levels and the related readjustment of project priorities and activities slow the rate of ongoing implementation.

C. Major Lessons Learned

- It is possible to conduct an extensive proactive curative and preventive health assistance program during armed conflicts by remote control from outside the country. It is not easy.

- A single donor (in this case USAID), with the proper implementing agent(s), can play the lead role in redirecting the orientation of health leadership from curative medicine to primary health care in a remarkably brief period.

- Outsiders, Americans included, underrate the potential for the provision of high quality maternal and child health care in Afghanistan. Respect for cultural values is the sine qua non for all such efforts. A willingness to consider all possibilities and provide strong support for promising ones is the next step, one the US health projects have taken.

- The absence of a cohesive internal (Afghan) coordinating body for managing external assistance leaves the responsibility for the coordination squarely with the donors and their implementors. This leaves the door open for both gaps and duplication (triplication, quadruplication) of efforts, Should an unfortunate situation require cross-border assistance in future, the US should demand coordination of its implementors, and request it from its partners, from the beginning.

- Issues of redundancy and sustainability of the health system can be dealt with unilaterally by one donor, as USAID has done here, but it takes conviction and organizational courage.

- Household surveys conducted by MSH and experience resulting from USAID-induced requirements for income generation in its project activities fairly conclusively demonstrate that rural Afghans will pay for health services.

- Creation of one-woman "posts" (where the MCHO is not physically part of a health facility with other staff) has a high rate of failure and is no longer supported.

- The flexibility afforded by a Cooperative Agreement compared to a contract make it the preferred mechanism in a situation subject to rapid change as has been the case in Afghanistan. USAID and the implementor both are better served.

D. Suggestions Should There be Follow-up by US or Other Donors

The following options are in keeping with the strategy document, and are variations of those themes.

- Option I- No program support until conflict resolution

This approach assumes a donor would be unwilling to mount a cross-border program, but would wait until the level of war-like conflicts would permit a more traditional program. The immense disadvantage is that all or most all traces of ongoing programs would have disappeared, and it would be necessary to rebuild it nearly from scratch.

- Option 2- Support the current EPI program

EPI is a highly cost-effective component of Primary Health Care, has a degree of national coverage and now is the most coordinated of all health programs. US-supported EPI is in place and intact and would need not interrupt its activities if funded. It lends itself easily to expansion and contraction.

If the urban population is not adequately covered, and if it represents the reported 20 percent of the total population, donors may be requested to help provide coverage for some or all of the urban population. Any EPI support should attempt to establish as many fixed points as possible.

- Option 3- Support the current MCH program

Training MCHOs, VHS and FHWs has little chance of centralization, perhaps not even regionalization, because of cultural constraints. It must be done locally.

Priority for MCH activities should be given in the following order because of receptivity toward MCH in the last 3 years: the Northern RHA; the Central RHA; from Paktika northward in the east because of receptivity and large populations. The South and Southwest Afghanistan Regional Health Administration is well down the list, with the southern provinces completely of the list.

More MCH clinics should be established by reestablishing the MCH refresher course in all regions to train available female providers, who in turn can train VHSs and FHWs.

Transferring the training of MCHOs to other regions will be difficult because of requirements for female trainers, living accommodations for students and the availability of sufficient clinical training facilities. The current IPH MCHO training personnel should become master trainers. If female trainers could be recruited for existing IPH training centers in Takhar and Balkh, the IPH personnel in those centers, if retained, could provide technical and administrative support. Similarly, the IPH technical staff in Kabul should be maintained for training and interface with other MOPH personnel.

- Option 4- Support both above programs in their entirety, or "defensible" pieces of each.

Because of progress made to date in both these vital programs, the ideal continuation would support both the foregoing programs in their entirety, keeping options open to further expand MCH and EPI services. A next choice might be to support both the above without considering expansion. Third, fourth and endless variations of this option, depending on the availability of funds, would be to support one or both programs in more limited geographic areas, perhaps down to one region or even one or several provinces.

I. BACKGROUND

A. Introduction

Since 1986, the United States Agency for International Development (USAID) has supported health projects from Peshawar and Quetta whose beneficiaries live cross-border in Afghanistan. The Health Sector Support Project (HSSP, 306-0203) is administered by Management Sciences for Health (MSH) and the PVO Support Project (306-0211) administered by three private voluntary organizations (PVOs), International Medical Corps (IMC), Mercy Corps International (MCI) and the International Rescue Committee (IRC). The original purpose of U.S. assistance was to provide emergency medical care inside of Afghanistan. As the situation changed in Afghanistan, the projects were modified so that the purpose became to develop and institutionalize the capabilities of Afghan authorities to operate effective health delivery systems and provide basic health care to Afghans living in Afghanistan. The predecessor project to the PVO Support Project was evaluated in November, 1989. The HSSP was evaluated in August, 1988 and February, 1990, and the projects were evaluated together in a health portfolio evaluation in February, 1992. After each evaluation, and particularly during the last years, attempts were made to increase the delivery of primary health care (PHC) services, particularly maternal and child health (MCH) services - which includes the expanded program for immunization (EPI) - intended to reach these two groups which had been inadequately addressed. MSH and MCI started MCH programs, and IRC supported several MCH efforts by Afghan non-governmental agencies (NGOs). MSH and IMC instituted or extended efforts in EPI.

In spite of the fall of the communist regime in April, 1992, all USAID supported programs continue to be managed cross-border because of continued political instability and lack of security. In July, 1991, an Asia Bureau-approved Mission strategy was approved for three stages of cross-border operations: the Survival Phase, which concluded with the fall of the communist regime in April, 1992; a Renewal Phase; and the Reconstruction Phase. In March, 1993, the Mission prepared a new strategy document focusing on the most urgent social needs of the country as a statement of how it intends to respond to those needs under the Reconstruction Phase. The Mission has been made aware that FY 1994 funding levels for all USAID supported activities will be significantly reduced from former levels. From three areas of support outlined in the latest Afghanistan Strategy, health and education are the two selected by the Mission for continued support, presuming continued funding. In health, the focus will be on MCH services provided by female workers and EPI. All other USAID health programs not directly supportive of these components will be phased out by the end of FY 1994.

B. Statement of Work

The evaluation is to cover only the MCH and EPI components of the four implementing agents supported by USAID, with an emphasis on MSH's experiences. General questions related to all four entities are to be answered, as are questions specific to each entity. Additionally, EPI/MCH/female training programs funded by other donors are to be reviewed as possible alternative strategies. Recommendations are to be made for effective implementation of an EPI and MCH program.

To the extent possible, background information requested in the SOW will be included in the report. The detailed Statement of Work appears as Appendix A.

C. Methodology

The evaluation was conducted by an external consultant provided through an Indefinite Quantity Contract with John Snow, Inc. The consultant had participated in the last two health sector evaluations. He arrived in Islamabad September 14, 1993 and was briefed by the Mission Director and the Afghanistan Field Operations (AFO) Health Chief and his staff. The next morning the AFO health staff and consultant drove to Peshawar, where a series of prearranged meetings were held with the three USAID-supported Peshawar-based implementing agents (MSH, IMC and IRC) and with other donors and implementing agencies concerned with EPI and MCH. On many of these meetings, the consultant was accompanied by the Assistant Health Officer. Planned meetings with members of Afghan Regional Health Administrations (RHAs), developed to provide pyramidal health services inside Afghanistan, did not occur because all activities had been transferred from Peshawar to Afghanistan. A list of people contacted appears as Appendix B. Document review was conducted entirely within Pakistan, as time did not permit review prior to the consultation, and the list of documents reviewed is Appendix C. Quetta was later visited to contact MCI and two private Afghan MCH clinics. Upon return to Peshawar, follow-up visits were held and a draft report begun. On October 11th, the consultant presented his preliminary findings in Islamabad to the USAID Director and Project Committee. Based on that debriefing, editing and additions were made and the report completed October 12th.

II. MATERNAL AND CHILD HEALTH PROGRAMS

The cultural constraints against women participating in the health delivery systems within traditional, rural Afghanistan have been discussed pessimistically and in some detail in previous evaluations and in many other publications concerning Afghanistan. A few years back, most male Afghans and nearly all donors thought that active female participation, beyond that of the dai (traditional birth attendant-TBA), was a very unlikely supportable donor activity. Traditional constraints are still strong, but some circumstances which have mitigated change and at least temporary liberalization of attitudes include:

- huge increases in the numbers of female physicians trained within Afghanistan during the Russian occupation. Anecdotal accounts relate that in 1980, about 5 - 10 percent of entering classes of medical students were women, whereas by 1990, about 90 percent were. The percentages are the estimates of a few female graduates, but the 10 year trend is universally agreed. What will happen henceforth is problematic.

- millions of Afghans in refugee camps outside of Afghanistan have been exposed to Pakistani and other foreign female health workers.

- donors have been consistent (and nearly unanimous) in urging greater female participation and generous in their willingness to finance innovative approaches to increase such participation by implementing agents, with the result that some approaches show promise.

- although the numbers are small, some Afghan physicians have been exposed to and have embraced primary health care (PHC) concepts promoted by donors - particularly USAID - which include community and female participation, and emphasize the importance of MCH. Many of these physicians now hold influential positions in the current Afghan Ministry of Public Health (MOPH).

The 1992 Afghanistan Health Portfolio Evaluation describes in some detail the beginning efforts by the USAID-supported implementing agencies in developing MCH programs delivered largely by females. The current status of the USAID-supported programs follow.

A. Management Sciences for Health

The 1988 HSSP evaluation recommended that MSH plan and implement MCH programs. By 1989, it had established an MCH Department within the MOPH of the (then) Afghan Interim Government (AIG), and had gained agreement from what later became

the four Regional Health Administrations (RHAs) for future MCH expansion. MSH added a female MCH advisor to its staff and undertook a number of initiatives. The development of these initiatives was congruent with the presence in Boston (at an MSH-sponsored training course) of the Director of the Institute of Public Health (IPH), who is now the Minister of the Afghanistan MOPH, at a time when WHO was trying to get the health officials of the communist Afghanistan government and those of the opposition to jointly develop a Masterplan for Rehabilitation and Reconstruction of the Health System in (postwar) Afghanistan. The IPH Director was a participant in this process, and was able to incorporate a number of suggestions for MCH which had come from his participation in the HSSP, his participant training, and from MSH home-office staff (Dr. Diana Silimperi).

1. MCH Facilities

By August, 1993, MSH had supported the establishment of 63 MCH facilities, of which 39 are still active and 24 canceled for a variety of reasons, including loss of female staff because of moving or non-attendance for whatever reason. Forty-one MCH Clinics - defined as having at least one nurse-midwife or female physician as part of the larger staff - had been established and 12 canceled, leaving 29 in operation. Twenty-two MCH Posts (where a female mid-level functions independently but in coordination with a previously existing health center) were established, and 12 canceled, leaving 10 active.

Most of the MCH Clinics and none of the MCH Posts have more than one female attached. Having only one female attached to a facility is one factor responsible for her leaving. Where there is but one female, frequently her husband is also working within the facility. Of the 39 active facilities, 32 are in two RHAs, the Supervisory Council of the North Area (SCNA), and the Health Committee of Central Afghanistan (HCCA). These areas hereafter will be called the North and Central Regions. In MSH's experience, these areas have been much more responsive to MCH activities than have been the South-Southwest Afghanistan (SSWA) Region or the provinces not under an organized RHA (please see Figure 1). While some MCH facilities have been established in the latter and supervised from Peshawar, the SSWA Regional Health Administration has not supported repeated MSH attempts to establish MCH facilities. Five were established, but all five failed to remain active. Ethnicity likely plays a part in the differences of receptiveness, but geography may also be a factor - MSH has not concentrated efforts in the non-RHA area (always working in areas with some semblance of regional civil administration) and is at a logistic and geographic disadvantage working in the SSWA RHA. The provinces in the North and Central Regions comprise approximately 50 percent of the Afghan population. (derived from Tom Eighmey's 1990 projections).

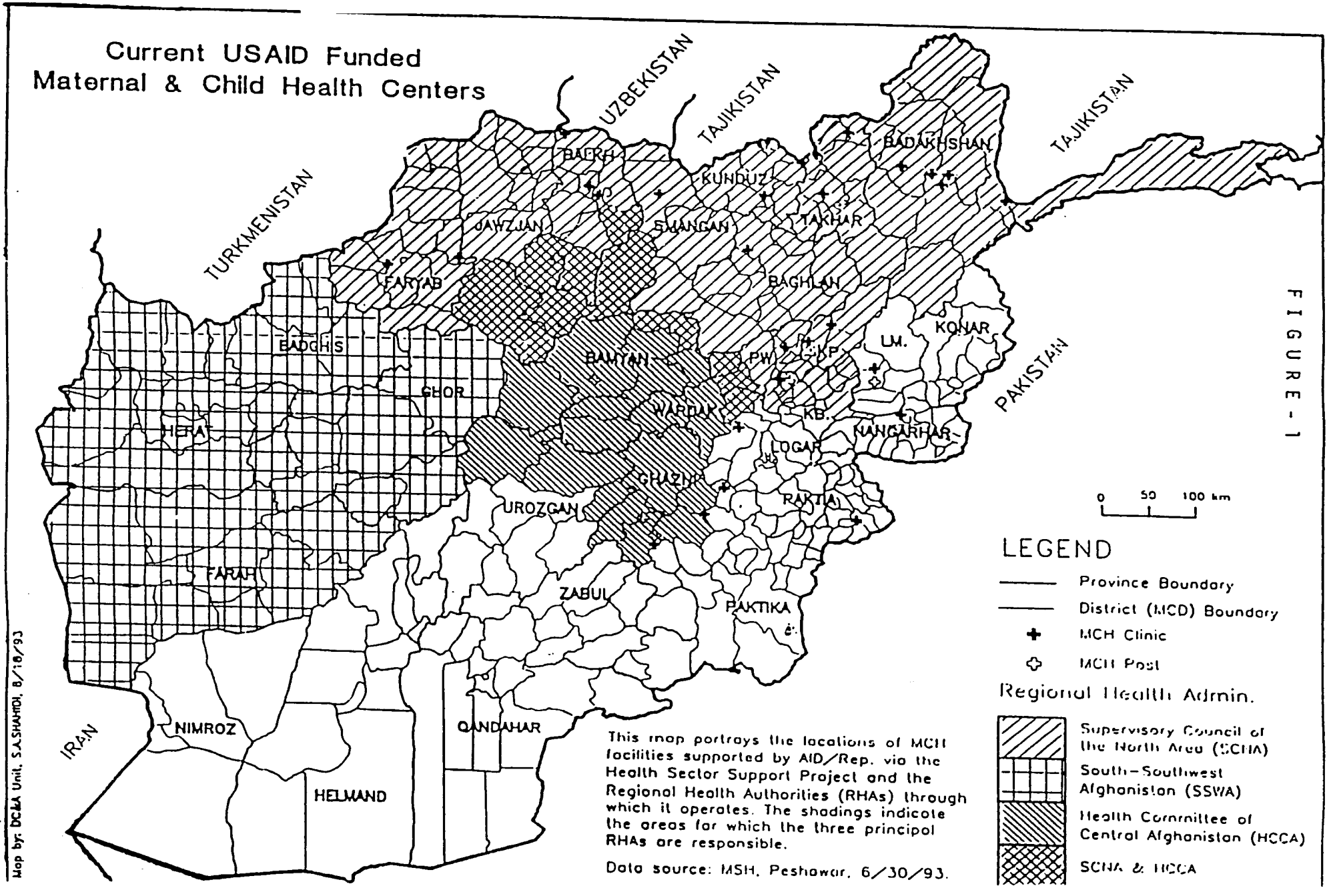

FIGURE-1

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The MCH facilities provide preventive and curative services for women and children, including prenatal, postnatal and very limited delivery services, treatment of common diseases of women and children, health education, immunizations, some oral rehydration corners and dai training. Thirty-three of the 39 facilities provide some family planning services: pills, and reportedly, some condoms. MSH's MCH division has analyzed the MCH facilities' "green books" and reports that 26 percent of women 14 and over coming to MCH facilities use one or the other method. While being unable to confirm the figures, use of modern methods of contraception including the IUD and pill by private MCH clinics in Afghanistan was reported to the evaluator by female physicians from those facilities.

In the beginning, MSH mid-levels were recruited from already trained female nurses, nurse-midwives, assistant nurses and medical technicians. Some of these were given a special 3 week MCH course in Peshawar during 1990 and 1991 prior to a facility being designated as an MCH facility. These courses closed when the training staff moved to Jalalabad. The course included concepts of PHC, management concepts, prenatal, natal and postnatal care, and instruction in dai training. In the future, if more MCH clinics are established, these or similar MCH courses will have to be reestablished for these existing categories of personnel. Initially these might best be placed in the existing training centers in Balkh and Takhar provinces. Additionally, the HSSP has developed two new categories of female health worker and training programs to produce them.

2. Maternal Child Health Officers

In late 1990, a facility was established by MSH and the Institute of Public Health (IPH) in Peshawar to train a new category of mid-level, the Maternal Child Health Officer (MCHO). The MCHOs are female health promoters and clinicians responsible for planning and supervising MCH services within their district or subdistrict level catchment area. This includes managing the MCH Post and providing: community-based training for Volunteer Health Sisters and/or dais; clinical services, prenatal, normal delivery and postnatal care and appropriate referral of women; preventive and curative services to children, particularly those under five; and community health activities from the facility.

In spite of extensive efforts to recruit candidates from inside Afghanistan, only 4 of the initial class of 11 came from inside (near the border) and the others were recruited from the refugee community. Training was by 3 physicians and one midlevel. The first class of 10 graduated in April, 1992. All ten were posted inside Afghanistan and 5 still remain on duty, one each in Nangarhar, Kunduz and Logar, and two in Kabul province. These women were posted to district or sub-district level MCH Posts.

The IPH moved to Jalalabad in September, 1992. A second class began in April, 1993 in Jalalabad, Nangarhar Province, after great difficulty because of cultural constraints recruiting 16 candidates from Nangarhar, Konar and Laghman provinces. One dropped out the first day and one with two small children soon thereafter. Qualifications were that they had to be from the above locations (verified), demonstrate sincere interest in health activities, have 8 - 10 years of education and be literate and able to write and speak Farsi or Pushto. The curriculum is in Farsi. All are aged 20 - 30 and have a relative in or near Nangarhar with whom they can stay during training. Five are unmarried.

The second MCHO 44-week course, (the first was conducted in Peshawar), started with the three month Basic Health Worker curriculum. All the current class passed and continued the program. Clinical training is done in existing hospitals and outpatient departments, and a graduate MCHO from the first class teaches outreach in a nearby village. A husband-wife physician team from Takhar came to spend a month learning to teach the MCHO course in order to able to initiate it in Takhar upon their return. According to MSH, this has not occurred because "of political instability and management problems within the health committee of the SCNA".

Supervision of the MCHO was planned to come in part from Provincial Health Officers, a short-lived category appointed by the AIG/MOPH in a few bordering provinces, and from MCH Regional Health Officers, of which three have been deployed (Nangarhar, Takhar and Ghazni). Much of the supervision of the few existing MCHOs is given by their trainers and/or by clinic personnel.

Performance of the MCHOs is difficult to assess because only a few are in operation. In May - June of 1993, physicians from the MCH components of MSH and the MOPH made a technical assessment of 6 MCHOs inside. Of the six, the facilities of two in Kabul were closed the day of the visit, but residents in the area were satisfied with the services. One supposed post in Logar did not exist and was subsequently canceled. One post was not visited for security reasons. Of a post each in Nangarhar and Kunduz, the assessment report noted:

- The posts are open 6 days a week. Female training programs such as the Volunteer Health Sister or Female Health Worker training programs are conducted two days a week for 1-2 hours in the morning.

- The staff of these facilities are using good prescribing habits.

- The MCHOs also make some home visits in nearby houses for curative services, emergencies, follow-up, etc.

- The green books are up to date and accurately completed.

- On the average, 30-40 patients daily apply to each MCHO post, 20-30 percent of whom are children under age 5 while 50-60 percent are women 15-45.

- Although 4-5 mild to severe malnutrition cases are diagnosed monthly in the facilities, there is no food provided for nutrition demonstration.

- Neither facility offered vaccinations. Contraceptives were distributed only to women who asked for them.

- Health education and community outreach sessions were conducted.

- These facilities did not sell drugs, but charged a service fee of 100 afghanis (about $0.06)/person which most people could afford.

The report also noted that unstable security, political conditions, difficulty of males supervising females, low levels of contraceptives and inadequate coordination between MCH and EPI services were constraints to improved services.

3. Volunteer Health Sisters (VHS)

The VHS is a new category patterned after experience with Urban Volunteers in Bangladesh. These women are being trained to become the community health workers found at the base of pyramidal health systems elsewhere. They are intended to function as the interface between the community and whatever formal health system evolves in post-conflict Afghanistan.

A series of 4 workshops, coordinated by MSH, was conducted in Peshawar between October 1991 and July 1993 to develop the concept and formulate the modules to be taught the VHS. Trainers of the VHS ideally are clinical personnel based in facilities in Afghanistan. Of the 14 VHS trainers, 12 are from inside in nine sites and two based in Peshawar. The inside sites are in Nangarhar, Konar, Ghazni, Takhar, Logar, and Paktya provinces. There were 4 other VHS training sites located in a non-MCH clinics which were closed because of the "redundancy" exercise described elsewhere. Ten are physicians, three medical technicians, and only one an MCHO. Ten of the 14 are men; some of these were able to teach directly, while others worked through female staff. The candidates for VHS training are selected by consulting with community leaders and recruiting women from patients visiting the clinic.

Because the trainees are rural or village housewives, they are able to receive training at the local health facility only an

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hour or so at a time, perhaps once or twice a week in classes of 3-6. Over a period of up to six months they are presented material contained in 7 modules:

-Personal Hygiene/Sanitation
-First Aid
-Safe Motherhood
-Nutrition
-Control of Diarrheal Diseases
-Colds and Pneumonia
-Immunization

Supervision is supposed to be provided by health facility staff and 3 Field Supervisors (2 MSH physicians, 1 MOPH physician). The Field Supervisors, all of whom have other training roles, were given a 3 day survey methodology course by Dr. Diana Silimperi in July, 1993. A 1993 workplan objective to develop eight VHS Supervisors did not transpire. The VHS role is to distribute messages about women's health and child survival, distribute basic health products such as soap and ORS, and refer cases as needed to the Basic Health Worker (BHW), dai or health clinic. She could also assist in arranging for community participation in EPI. She is supplied a health promotion bag with posters, a liter measure, soap, ORS packets, a marker pen and pictorial record, but no financial or other compensation from the formal health system. From August of 1992 through July of 93, 73 VHS were trained. The workplan target of a total of 200 to be trained during FY 1993 was not achieved.

A May-June 1993 assessment of the nine training sites inside Afghanistan indicated that a monitoring system had been established at all sites, and that both the trainers and the VHS knew how to fill out the monitoring tools (although one-third of the latter did not turn them in monthly). A direct or indirect supervisory mechanism was in place, and usually occurred on a monthly basis. Almost all the VHSs were referring serious cases to the clinical facilities, and results of interviews with some of the VHSs showed that they had retained most of what was taught to them. There was some evidence of a trickle down effect (Oh, Ronald, where is thy sting?) in that some school teachers have been trained by a trainer in one area, supplied, and are passing messages to their families as well as to their pupils. In another location a physician trainer team has trained some of the female staff of their clinic to assist them in this training.

4. Female Health Workers (FHWs)

Traditional birth attendants, or dais, are the raw material intended to become FHWs through MSH training. In contrast to TBAs in many countries, according to the WHO-coordinated Masterplan for Rehabilitation and Reconstruction of the Health System in Afghanistan, Afghan TBAs attended only 0.5 percent of deliveries of Afghan refugees in Iran. It states that in Afghanistan, the dai provides pregnancy related care only to members of her extended family and may only deliver 8 babies in

her lifetime. On the other hand, Dr. John W. LeSar wrote in the 1980 Managing Health Systems in Developing Areas that "about 75 percent of births in Afghanistan are still attended by the traditional village dai (15 percent by female family members and 10 percent by western-type practitioners)". This wide variation of opinion (150 fold) could stem from improper assumptions by one or both estimators, by radical changes of practices over a startlingly brief time period, or from widely differing sample populations. (Three Afghan physicians in the MSH MCH department were disbelieving of the 8 babies per career statement. It was their belief that dais usually deliver 6 - 8 babies a month. Similarly, an MSH household survey of Takhar Province carried out in 1991 revealed that dais attended 54 percent of the deliveries in the three district sample). The evaluator could find no estimates of numbers of dais existent in the country, but even the WHO document forecasts a need for at least 32,000 trained dais, or one for every village.

At one time, 25 females of the 76 then in facilities supported by MSH were known through assessment to have conducted FHW training programs. By August of 1993, 10 of these facilities had been canceled, leaving 15 known training activities at the time of the evaluation. These trainers were taught how to teach the dais during their 3 week MCH inservice training at the time their facilities were being established as MCH Clinics. The FHW is a dai who is trained to deal properly with home deliveries, perinatal health and child health in her community. These women apparently are nearly universally illiterate, and like the training of the VHSs, their training is given in periods of 1-2 hours several days a week and may take up to 6 months to complete. Approximately 457 have been reported trained to date. They are expected to make home visits for pregnant and post-partum women, refer high risk cases, conduct sterile deliveries, and disseminate basic child survival information. Supervision is by each dai's instructor. Upon completing the course, they are presented with a kit containing soap, razor blades, string, gauze pads, a nail clipper, and ORS. They receive no compensation from the health system.

In the May-June VHS, FHW and MCHO assessment mentioned previously, 14 FHW training sites were planned for visitation. Of the 14, three were in insecure areas, and one trainer was not at her post. The remaining 10 sites in 9 provinces (Kabul, Kapisa, Logar, Ghazni, Paktya, Nangarhar, Laghman, Takhar and Kunduz) had trained or had nearly completed training of 297 FHWs, 70 percent of whom had been dais. NOTE- in each site, efforts were made to enroll as many known dais as possible. Where training capacity existed, women indicating the desire and ability to receive the training were accepted. The complete course includes 16 topics from a FHW Teaching Manual prepared by the UN High Commission or for Refugees. The topics range from hand washing through vaccination on the general health side, and

much attention to management of normal deliveries and danger signals of abnormal pregnancies and labor. The two MCH physicians conducting the survey interviewed 14 FHWs from 5 facilities, and rated the knowledge of 6 FHWs excellent, 5 good, and 3 fair. There appeared to be a strong correlation in this small sample between the trainer the FHW had and how she fared during the assessment. All the 'excellent' ratings came from 3 trainers, all the 'good' but 1 from 1 trainer, and all the 'fairs' from one trainer.

B. International Rescue Committee

The International Rescue Committee was one of the first significant assistance programs to begin refugee relief operations in Pakistan, having begun in early 1980. Historically, IRC provided funds for activities on both sides of the border, initially working largely through non-Afghan PVOs. Beginning in 1986, USAID established the PVO Co-Financing Project which financed two kinds of activities: "cash-for-food" (later split off into a Rural Assistance Project - RAP), and programs to train health care workers to staff clinics in war-affected areas. Beginning July 19, 1989, through a Cooperative Agreement amended several times since, the IRC has provided grants to PVOs qualified to provide health care assistance inside of Afghanistan. Initially, IRC served mainly as a "pass through", but later took a much larger role in soliciting proposals, reviewing and providing technical suggestions, monitoring, supervision and evaluation. As events unfolded inside Afghanistan, IRC and USAID agreed to shift away from emergency medical assistance for refugees and Pakistan-based projects, and beginning in 1993, in the health area, funds were concentrated on primary and preventive health projects that improve and protect the health of women and children. Priority has now been given to Afghan PVOs and to projects that incorporate some assurance of sustainability.

1. The Afghanistan Obstetrics and Gynecology Hospital (AOGH)

The 1992 Afghanistan Health Portfolio Review discusses the AOGH:

> "Through the PVO Support Project for health activities, IRC funds the 24-bed Afghan Obstetric and Gynecology Hospital in Peshawar. This crowded facility provides in-patient care for more than 500 women/month and out-patient perinatal care for more than 2000 women/month. Patients are refugee women from throughout the North West Frontier Province. All of the staff are female, and this includes more than 10 Afghan physicians, some of whom volunteer their services. This facility also serves as a practical training site for the students of the nearby MCHO center. The Afghan medical

director and founder of the hospital is planning to move the facility into Afghanistan (Nangarhar province) in the future; he hopes that it can serve as a practical training center for the medical school in Jalalabad".

The AOGH was founded in 1984 by an Afghan refugee physician (Dr. M. Hussain Momand) and an Afghan OB/GYN physician from the United States. IRC/New York had been one of the original donors. From 1989 through February 28, 1993, IRC/USAID provided $405,876 to the hospital. Additionally, female staff from the Swedish Committee for Afghanistan, the Ministry of Public Health, Save the Children Foundation-UK and The Austrian Relief Committee all received clinical training at the AOGH.

After considerable planning, including sending two missions to Jalalabad to consider options for moving, the AOGH decided to move to the private property of Dr. Momand. IRC was not willing to support a private clinic, so its funding ended February 28, 1993 when the Peshawar hospital closed. Another AOGH donor, the Norwegian Refugee Council/Norwegian Church Aid, with little consultation with other donors, agreed to finance both the cost of renovations and the cost of moving from Peshawar. The clinic moved in January, and the remainder of the hospital in May. The clinic is seeing 70 patients a day. Children are not treated except for vaccinations. The present hospital has approximately 30 beds. There are 25 total staff, about half of whom are from Jalalabad. The professional staff, all women, includes 3 senior OB/GYNs, 6 junior OB/GYNs and 3 anesthetists. The British Peace Corps equivalent, Volunteer Service Organization (VSO), has provided the services of a female Medical Director and a Hospital Manager. A female American Physician Assistant, who was the Deputy Director for the hospital from 1998 - 1993, is currently a Peshawar-based Liaison Officer paid by the AOGH. About 8 percent of the outpatients come in specifically for contraceptives, including Depo-Provera, pills (they don't have the progesterone only), condoms and a few IUDs.

2. Mujahid Emergency Medical Center (MMC)

The MMC was founded in 1989 by Dr. A. Reha to provide emergency first aid and surgical services to wounded mujahideen in the Jalalabad area and in the suburbs around Kabul. After the fall of Jalalabad to the mujahideen, he developed a polyclinic in Jalalabad which offers a full range of services including emergency surgery for accidents, including injuries from gunshots and mines, an OPD serving women, children and men, immunizations, dentistry, a lab for malaria and tuberculosis testing, and a delivery room for mothers.

The clinic, which started in a schoolhouse, has seven medical teams on staff. One team contains 2 female physicians and 4 Lady Health Visitors (several of these latter are 3rd and

4th year medical students and the others are nurse-midwives).

On March 15, 1993, the MMC was awarded a 10 1/2 month grant by IRC to provide salaries for these female professionals to deliver health education by personal visits twice weekly to homes in a community of about 2000 households near Jalalabad, provide regular MCH services three days a week in the clinic, and present talks on "Family Health" in Jalalabad girls schools. Initially the teams (and one additional nurse) were presented lectures on: breast feeding and weaning practices; nutrition, solid foods and cooking demonstrations; first response for mine victims; vaccination promotion; ORS and diarrheal management; care of the underweight child; personal hygiene; and, antenatal and post natal care. There is a regular program of monthly continuing education.

Each team is comprised of a doctor and two Lady Health Visitors. Since 2-5 families reside in one compound, a home visit usually involves 12 - 15 members of the extended families. In addition to providing health messages, the team refers the sick to the clinic, promotes immunizations and presents soap and a towel to the mothers of newborns. They use flip charts in their presentations. Dr. Reha (unasked) said the team also gives "indirect" family planning, by which he meant advice if they were asked. The visitors do not have or provide contraceptives.

The women are in the clinic three days a week, including Saturday which is set aside for MCH services, during which they provide supplementary feeding of a cereal, milk powder and a biscuit provided by UNICEF to undernourished 6 - 16 month olds. The doctor provides surgical/ medical services also in Kabul where the International Committee of the Red Cross provides similar rations. The other major day at the general clinic for women and children is Tuesday.

There is a good deal of clinical malaria, with fever cases running up to 50 percent positive. Both falciparum and vivax are found, and he has found no chloroquine-resistant falcip.

The clinic is not an inpatient facility, being quite small. As necessary, referrals are made to the Public Health Hospital, AOGH or University Hospital in Nangarhar, or to Peshawar.

From March through August, 1993 the teams had visited approximately 210 families, Immunization records were well kept according to an IRC monitor, and the facility's project reports indicate the following (March - August, 1993):

29

MEASLES- 448

BCG - 960

DPT-POLIO
DOSE 1- 1009
DOSE 2- 953
DOSE 3- 719

TETANUS TOXOID
(PREGNANT)
DOSE 1- 252
DOSE 2- 217

TETANUS TOXOID
(NON PREGNANT)
DOSE 1- 154
DOSE 2- 74

Dr. Reha told the evaluator he had been trained as a psychiatrist but because of circumstances, he was doing a lot of surgery. He and a fellow physician are being sponsored soon on a study trip to Norway for surgical techniques.

III. Mercy Corps International

Mercy Corps International (MCI) operated from Quetta for five years under a USAID grant, with the health sector being but one area of assistance. It managed a large USAID-assisted agricultural program as well. Effective June 1, 1991, the contract was replaced by a Cooperative Agreement. At the time the Cooperative Agreement was signed, USAID funded a hospital-cum-training facility and an MCH Clinic in Quetta, and 39 clinics cross-border.

As a result of several amendments in 1992, USAID withdrew its support of all MCI service and training activities in Pakistan and approved support of five MCH sites inside Afghanistan in Ghazni, Helmand and Khandahar provinces. Training of up to 21 MCHOs in Afghanistan was approved, contingent upon demonstration that the training would follow a standardized course. The implication was that the course to be followed was the MSH-developed MCHO course, since this was the only such course being offered. It also required transfer of all MCI administration and training to inside Afghanistan over a six-month period. Also approved was the operation of nine facility-based immunization teams in Ghazni, Helmand, Kandahar and Oruzgon provinces, contingent upon a plan of coordination with other immunizing entities. Standardization of salaries and incremental salary reductions of 50 percent by January 1, 1993 was called for (as was the case with all USAID-funded implementing agencies), and a requirement levied for income generation at the clinics.

1. EPI Activities

For reasons that are not clear, in spite of the fact that USAID had agreed to support EPI, MCI opted to secure funding from another source, align itself with AVICEN and not use USAID funds for EPI. Six of the proposed nine teams were activated, and AVICEN arranged cold chain equipment and vaccines (paid for by MCI) to be moved to Kandahar. MCI has decided it will not charge

for EPI immunizations in the clinics which offer them, even if charges are made for other services. Later, additional vaccinators were given refresher courses by AVICEN and deployed inside, bringing EPI services (not funded by USAID) into a total of 9-10 USAID supported clinics.

2. Training and Maternal Child Health

The February 1992 Health Portfolio Review noted that:

> "Although the recruitment and training process is still unclear, MCI does have a number of plans to train a variety of female health personnel within Afghanistan in the future. These will include: 6 mid-level health workers to support its planned MCH clinics; 10 MCH Assistants; and 320 Community Health Promoters (dais and other women). A total of 10 MCH annexes are planned for the future in conjunction with MCI clinics, along with one MCH center."

The MCI training center eventually was moved to Kandahar City opening in a renovated Mir Wais hospital where MCI hoped to provide the standardized Combined Mid-Level Continuing Education Program as it had in Quetta. Students were recruited, and the training started several times only to be disrupted by fighting and severe damage to the training facility. It finally was begun again on June 12 with one MOPH, 7 Swedish Committee for Afghanistan and 6 MCI trainees, the plan being to finish prior to October 31, 1993.

Having received earlier USAID permission to undertake MCHO training once standardization of the course was accomplished, Dr. Imam, the MCI Health Division Head, participated in a series of meetings with MSH and the IPH, where agreement was finally reached on the content. He was not happy with this process, feeling that MSH and IPH dominated the discussions and included too much management and administration along with the clinical materials. At any rate, once standardized, MCI requested USAID approval to begin an MCHO course in Mir Wais, only to be refused on the grounds that because of the forthcoming phase down and closure of USAID-funded activities by October, 1993, there would be insufficient time for training and deploying the graduates of this one year course.

MCI hoped to establish 9 cross-border facilities offering female-provided MCH services, but have established only 3, that being the number of female providers it could attract. One provider has left, and the other two (a nurse and an MCI-trained MCH Assistant) are the only women in their clinics - this is possible because both of their spouses are also employed in the clinic. Dr. Imam stated that some MCI clinics with only male providers were serving up to 50 percent women and children, but, unfortunately, he provided no documentation. Like other clinics,

clinics with MCH annexes are monitored about once a year by the MCI monitors, but the monitors this year were very busy assessing the aftermath of the chaos in Kandahar. The very busy MCH clinic apparently remained in operation in Quetta in a new location, but along with training of TBAs in refugee camps around Quetta, was supported by non-USAID funds.

After the transfer of two clinical facilities to the Regional Health Administration of the South and Southwest, and the "redundancy" exercise and subsequent negotiations (see the discussion at the end of this chapter), USAID support of cross-border clinics was reduced to 25. MCI was notified by USAID on February 21, 1993 that all currently-funded programs would likely be phased out by April 30, 1994 with all inside support to cease February, 1994. MCI interpreted this notice regarding the totality of USAID programs to mean that its Cooperative Agreement had somehow been extended to that date, whereas its Cooperative Agreement had been extended only from June 30 to December 31, 1993. MCI, then, was surprised to be informed (on May 19, 1993) of the December 31 closure date with inside activities to cease on October 31, 1993. Its phase out plan, first submitted in April, was subsequently revised several times to come into conformity with USAID intentions.

MCI has long had interest in MCH care in Quetta, and its facility for care of refugee women and children was a model. It was slow to try to move its administrative and training activities inside Afghanistan, which of course is the thrust of the Afghanistan PVO Support Project. When it did make the inside move, Kandahar repeatedly became a war zone between conflicting Afghan groups, and planned MCH activities, including an MCHO course which MCI very much wanted to conduct, were refused by USAID because of the forthcoming phase out. MCI very rightly points out that the quality health care provided women, children and (at the risk of being sexist) men in its clinics likely will be lost when the responsibility for these remaining clinics is transferred to the Afghanistan MOPH, given the dearth of resources available to that group. It is for that reason that MCI is searching for other donors for its USAID-supported activities, and may explain why it sought other donors early for its EPI activities.

D. Discussion

There are many indications of a large unmet demand in Afghanistan for MCH services which minimally include immunizations, nutritional supplements, control of diarrheal diseases, better prenatal, natal and postnatal care, and contraception. In the few years that these projects have given increased emphasis to MCH, significant inroads have been made to bring modern primary care to mothers and children in a culturally acceptable manner, with women themselves willing to actively

participate not only in the care of their own extended family, but in the care of the much wider community. Experiences have been short, but in a few short years implementing organizations supported by USAID and other donors have been able to reach, and teach, illiterate TBAs, who participate quite willingly in programs to increase their skills with very little tangible incentives and with no remuneration from the health system. Nearly all programs rely on UN-prepared materials, or derivatives thereof, for the teaching materials. The use of those materials worldwide has been effective in changing health practices and health status where it can be measured. It is nearly impossible in Afghanistan today to demonstrate either change in health practices or status due to any intervention (and none can be documented with any certainty in this project). The interventions taught have worked worldwide - it is with some high degree of certainty that the interventions are producing some change even now, but proving this will await settled conditions. Reaching the dais with proven, practical and usable information, as has been done by MCI in the refugee camps and MSH at scattered sites inside Afghanistan, in the long run might be the most important contribution - NEXT TO EPI - that the USAID cross-border health portfolio makes to improvement of health status of mothers and children during the next decade.

Until it was tried, it was general knowledge that the idea could not work of recruiting illiterate village female volunteers in Afghanistan to be taught the rudiments of health care, how to be referral agents for basic primary care interventions and community interfaces with the formal health system. But then it was tried. Experience has been short, but encouraging. In nine training sites inside Afghanistan, at least 73 of these Village Health Sisters have been trained, and early professional assessment, though with a painfully small sample, is positive. Everything else being equal, VHSs trained by females likely are better trained and better motivated than those trained by men, but at this point we do not even know this. We do know that some of these uneducated VHS were trained by male health providers from the volunteer's community, something else that was thought highly improbable.

After much agonizing, the MCHO curriculum was developed, educated candidates recruited - albeit few from across the border initially - and a new category of midlevel specifically developed to respond to the health needs of mothers and children trained, deployed inside; half are still at their jobs. Preliminary assessment is promising enough that it looks worthwhile to push hard to further develop the skill, deployment and retention of this very important part of the pyramidal health structure. Multiple training sites will be necessary - women must stay near their home and must observe purdah, but it has been shown that it can be done, at least experimentally. It might not work in all parts of Afghanistan, but it surely won't if it isn't tried.

In the past decade, there has been a relative spate of female physicians graduated from Kabul, many of whom are widely disbursed throughout the country. If some female physicians and nurses post-conflict can be induced to stay in the periphery, the current MSH experiments with MCH clinics may radically change access to MCH care in the country side. Maximal benefit of a pyramidal system occurs only if there is high level curative, as well as preventive, services back-up to the services rendered at the mid and basilar levels of the pyramid. Experience with female high level (physician) providers at the AOGH in Peshawar and in Jalalabad, at the Mujahid Emergency Medical Center in Jalalabad, and at Afghan NGO female-led clinics in the refugee community, indicate the services will be used heavily when women, their family and their mullah know their cultural mandates will be respected.

The evidence that MCH clinics do increase attendance of women and kids is slim, but suggestive. The MSH physician responsible for MCH has analyzed the green books from recently established MCH clinics and found that 43 percent of the patients are women, 35 percent children (both sexes) under 15, and about 18 percent men. These are clinics with at least one female provider. The 1992 Health Portfolio Review quoted a figure of 20 - 30 percent female attendance at general clinics, citing a 1991 Provincial Health Resources Survey/Health Facilities - Preliminary Results by Youssef Tawfiq of MSH. Not conclusive, but suggestive. One might presume that the percentage of obstetrical and gynecological complaints treated at the MCH clinics was much higher, but at this time it, too, is only a presumption.

That there is latent demand for contraception has been documented above in MCH clinics, the AOGH, and the MMC. A female physician head of an Afghan NGO clinic operating cross-border took across 200 IUDs, and was surprised how rapidly the supply was exhausted. These examples are particularly interesting because most providers report they provide information and/or services only when asked, and they usually deny actively promoting contraception. There may be a significant health benefit ahead when women more openly may learn of the health benefits of spacing or reduced fertility.

A major constraint to training more females in MCH has arisen because of the difficulty in recruiting female trainers for them. Those that MSH has recruited are excellent, but it can not be assumed that they are readily available should expansion be undertaken.

The monitoring systems used by all USAID-supported cooperating agencies is well described in the 1992 Afghanistan Health Portfolio Evaluation. The methods described are largely "head-count monitoring". MSH, with the most to monitor, reports

for the quarter ending June 30, 1993, "From the beginning of the project until the end of this quarter, the MSH Monitoring Unit had monitored 2199 Basic and MCH Health Posts (out of a total of 2271 BHWs initially supplied) and 275 Basic, MCH and Comprehensive Health Centers and hospitals (out of a total of 292 established. The majority of MSH-supported facilities have been monitored more than once. As a result of improved monitoring, MSH support was withdrawn from 1163 inactive or redundant posts and 122 clinics and hospitals." Because of the enormity of even the head-count type monitoring, non-existent clinics may go for months without the information reaching MSH. Technical monitoring presents even a greater challenge. Good technical evaluation tools have been developed and tested, but few technical evaluations completed. Exceptions are highly informative, and usually positive, the VHS, FHW and MCHO Programs Assessment Report being an excellent example. Similarly, an IRC assessment of the Mujahid Medical Center another. Technical assessment of the BHWs is easier now, as there are fewer of them and more assessment areas (internal resupply points).

Most of these changes occurred in the past three years under particularly stressful times for the USAID-supported health providers. USAID undertook two courageous but thoroughly demoralizing (to Afghan providers) steps during approximately this same time. As a move towards post-conflict sustainability of USAID contributions to health care of Afghan civilians, USAID imposed an incremental reduction of salaries across the board in facilities it assisted, 50 percent reduction for clinical and support personnel, 25 percent for preventive and teaching personnel. This was done in the absence of similar actions by other donors, the intent being to introduce income generation in the form of fee-for-service, clinic fees, lab fees, etc., to introduce the concept of client cost-sharing. The move is a reasonable one, because the Afghan government, even with heavy donor assistance, will not be able to bear the salary levels provided by current donors. In some cases, these reductions were sufficient to bring them below what the health workers could make in the military, and some were lost to the army. Many others threatened to quit when their medical supplies ran out, and some did quit. The fact that staffing levels remain as high as they are indicates that this was not the fatal blow that many expected it to be. Some of the implementors who resisted this move most vocally initially have greatly softened their objections as various cost sharing schemes have emerged. The other move, conducted during the past year, was a requirement that health facilities supported by USAID through its implementing agencies that were within 10 kilometers of another facility and were in a population of 30,000 or less were declared "redundant" and had to be moved or closed, unless the implememting agency could justify its continuation. This process was highly disruptive, particularly when the WHO data base upon which the location of all clinical facilities - no matter their source of funding - was

predicated was not always accurate. The information in that data base had been submitted by the implementing agencies. Some of the information supplied by MSH, and probably other USAID-supported implementors, was dated and inaccurate. Time spent on this exercise decreased the technical advisory time available for other tasks, including attention to MCH. The process did have the beneficial effect of cleaning up the WHO data base and those of the USAID-supported implementors, making them more accurate than ever before. Consideration of declaring MCH clinics redundant was NOT part of this exercise.

Two other circumstances beyond the control of USAID also detracted from the ambience. One was the general disappointment felt by all in Peshawar that internal conditions in Afghanistan did not permit the long awaited move inside and the prayed for cessation of foreign assistance by "remote control". Finally, the brutal reductions in Mission funding levels hit at the very time that there was an increasing momentum in MCH activities by USAID-assisted entities. This then had to be stemmed. For example. With USAID's agreement, IRC had solicited proposals from Afghan NGOs for PHC activities, and had over a dozen on hand when it was informed that none would be approved. MCI's experiences were noted above. Such are the realities of the politics of foreign assistance. It is a tribute to their professionalism that the implementing agencies were able to accomplish the meaningful things they did.

Of the USAID supported entities, MSH has had the largest financial investment in the MCH program. Since 1989, the total MCH program costs, which do not include technical assistance or the costs associated therewith, total but $1,132,288, Amongst the benefits beyond the direct care provided by the newly trained health personnel are tested curricula, teaching methodologies, experienced trainers and vastly different concepts of health care delivery which are available to the future architects of the post-conflict health care system.

III. EXPANDED PROGRAM ON IMMUNIZATION

MSH by far has provided the lion's share of USAID project assistance to EPI.

A. Management Sciences for Health

Planning for EPI activities began soon after the MSH Technical Assistance Team arrived in 1987, and field activities began in 1988. In 1989, the first vaccine storage facilities (VSFs) were established inside Afghanistan, in the Northern Regional Health Administration.

From the beginning of the large increase of international assistance to health activities in Afghanistan in the early and mid 1980s, coordination of EPI activities has been extremely difficult. Many early efforts seemed to come to naught because of different implementing organizations having different agendas and varying degrees of willingness to even try to coordinate their EPI (or any other health activity) with anyone. AVICEN, the Afghanistan Vaccination and Immunization Center, has conducted one of the largest EPI programs since late 1987, but for much of this period has shown little willingness to cooperate with anyone, including the donors upon which it has been dependent. Another cause was the earlier unwillingness or inability of the UN agencies to take their normal central coordinating role. In their defense, WHO and UNICEF, as programs working government to government, were largely concentrated in Kabul while most of the Western external assistance was flowing cross-border from Peshawar. Communication between the Kabul-based UN agencies and their representatives in Pakistan were laborious at best, nonexistent at worst. As a result, most implementing agents participated in seemingly endless series of meetings intended to rationalize the rural EPI programs being assisted from Peshawar, but at the same time continuing individual cross-border programs.

While still imperfect, much progress in coordination has been made. One important event has been the assignment of an effective health officer and a highly qualified and experienced EPI Officer to the UNICEF group, and since the fall of the communist government, their participation in EPI activities stemming from both Kabul and from Peshawar. Over the past year, coordinating meetings were held monthly or every two weeks until this past May, and territories laboriously agreed upon and divisions of labor agreed upon. Standard reporting mechanisms were also worked out, and use of a standardized supervisor's checklist was being discussed when these meetings were discontinued. Of interest, the Kabul MOPH official responsible for EPI was able to attend several of these meetings. Though there are still many different groups providing some immunizations, MSH informally estimates that the Kabul MOPH,

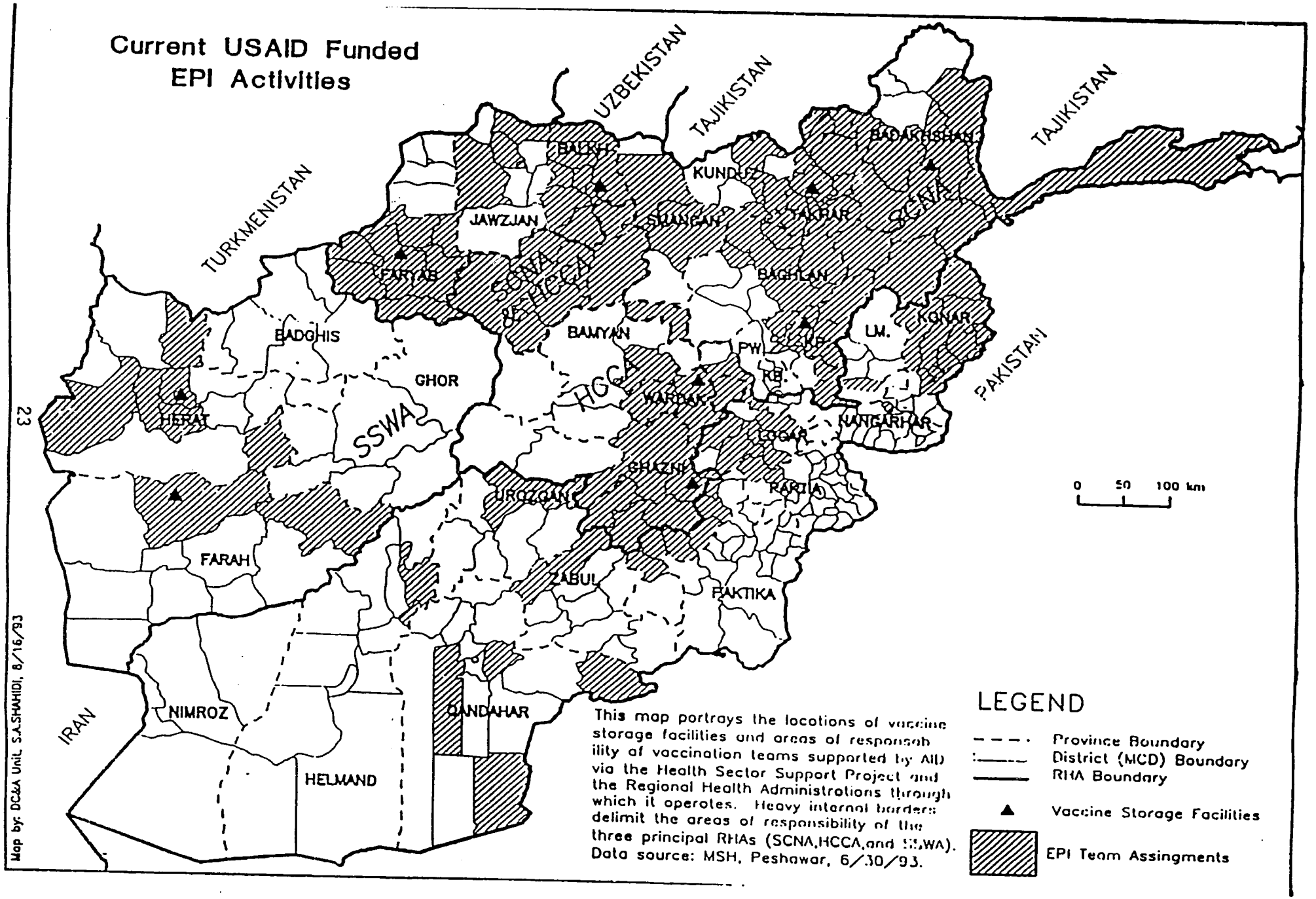
AVICEN and MSH provide about 80 percent of all vaccinations occurring in Afghanistan. All groups have the potential to reach up to 71 percent of all the under twos in the country.

From the beginning of the MSH assistance, UNICEF has supplied most all the vaccine used in the EPI program, although shortfalls in UNICEF funds dedicated to vaccine purchase made it necessary in parts of 1990 - 1992 for both MSH and AVICEN to purchase some vaccines. In contrast to most other entities, MSH has been self-sufficient for all EPI support except for vaccines, while other implementors in varying degrees rely on UNICEF for syringes and support costs for field teams.

Figure 2 shows the geographic distribution of USAID-funded EPI activities. The Preventive Medicine Department (PMD) of the old AIG/MOPH is responsible for coverage in the South and Southeastern districts which are under no RHA. These activities are run from a VSF in Peshawar. These EPI activities are funded by the HSSP and reporting is included in MSH reports.

The remainder of the HSSP EPI activities are operated through the North, Central and Southwestern RHAs, which are supplied from 9 MSH-funded VSFs (Figure 2). Within the country also are an unknown number of MOPH VSFs, about 4 of which are thought to be functioning. AVICEN maintains 8 VSFs and Norwegian groups two. Most of these VSFs are funded by the European Community (EC) or bilateral donors. In theory, any approved vaccinating group can draw supplies from a given VSF, but MSH and AVICEN tend to use their own. The Kabul MOPH shares MSH VSFs in several locations where its own facilities are inoperative.

There are a total of 254 MSH-funded vaccinators, about 6 of whom are females. Most of the vaccinators have been trained by MSH, and the five trainers also give refresher training. MSH initially trained some of the vaccinators from the North RHA away from their homes, but many then left. Accordingly, training then was given more locally near the VSFs. A doctor or doctor assistant provides medical and overall supervision of the personnel operating from each VSF, and the primary responsibility for the cold chain lies with 9 cold chain supervisors, 17 cold chain technicians and 4 EPI plant supervisors. Adding administrators, logistics officers and other support crew, the MSH-supported inside EPI contingent totals 333. In Peshawar, MSH maintains an advisor responsible for support of communicable disease activities including EPI, with three technical support staff. The Peshawar-based VSF utilized by the PMD employs 2 technical and 3 support staff, and the PMD itself has a director and deputy-director, 2 staff backstopping field operations and two training officers. When the MSH support started, PMD vaccination teams averaged 6, but when the RHA-deployed teams were established, the RHAs thought 2-3 were enough. Experience has shown 4 man teams provide as much coverage as the previous



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6 man teams, and this has been established as the standard. There has been remarkably little turnover of all categories of EPI workers. The largest turnover has occurred with the vaccinators (only 88 in six years), and most of these have occurred during the last year since USAID required an across-the-board pay reduction of 25 percent for EPI workers as part of a larger plan to foster post-conflict sustainability.

The PMD teams are paid and supplied in Peshawar, while the RHA-based teams operate from the administrative centers associated with VSFs. The RHA-based groups do not operate as rigidly set teams, but can be assigned as part of fixed, outreach or mobile teams. When fixed, the vaccinator spends as long as is necessary in a clinic or hospital, especially MCH Clinics, to assure that on-board personnel are using proper technique and recording properly, or, alternatively, providing the vaccination him/herself. Outreach teams operate in the catchment area of a fixed clinic and in coordination with it. Mobile teams operate in no relationship to a fixed clinical facility and probably account for 50 percent of the total activity. Efforts are being made increasingly to have more activities tied in with an existing facility, particularly MCH clinics as more come on line. The communities know a day or two in advance of a forthcoming visit from mobile teams by newspaper announcements (!) or by an advance man who contacts the commanders, elders or other leaders. In theory, there is little overlap of territory by the major vaccination providers, but even should they overlap, they are using a common set of patient-held EPI record cards, so they fill in the card already started by the other group rather than providing a new card. Some smaller groups, new to the program, may violate this approach and ignore previous efforts, but this is increasingly rare and quite unlike the anarchy said to have existed earlier. District records are collected by the administrative cold chain supervisor, checked by the physician and sent in a standard format to MSH Peshawar. After review, MSH forwards the data to UNICEF Peshawar, who has responsibility overall for the records, and the information is then sent to Kabul UNICEF where it is passed to the MOPH.

Monitoring occurs in several ways. The MSH monitors operated by the Field Operations branch periodically do "head-count" (non-technical) monitoring, similar to monitoring done of Basic Health Workers and health facilities. The medical personnel and administrative Cold Chain Supervisor (CCS) of each VSF provide some technical supervision, and this is confirmed periodically upon their return to Peshawar. MSH is also urging the VSF CCS to periodically do 75-household sample surveys, matching the vaccinator's claims against the record cards of the 75 households. The community members are quite good about keeping their record cards, and the correlations with the vaccinators' reports are high. AVICEN did a more sophisticated stratified cluster sample survey, the findings of which were similar to

MSH's - 70 or 80 percent first dose coverage and subsequent high dropout rates (see discussion below). Even these relatively small sample surveys are difficult to conduct. Better and/or more wide spread information likely will await some semblance of settled conditions. UNICEF has done limited technical monitoring. As is the case with other USAID-supported health activities, an additional but infrequent source of monitoring is USAID's Data Collection and Analysis (DC&A) Unit. There is a very high degree of correlation between the DC&A findings and MSH's knowledge.

AVICEN is very good technically, but has been reluctant to line up with any indigenous Afghan authorities, and belatedly is trying to make up for it with the Kabul MOPH. Like others, AVICEN is reported to be having difficulty maintaining financing. Its funding comes largely from the EC and several bilateral sources, including France, Norway and possibly Australia. Should AVICEN's very considerable programmatic inputs disappear, effective EPI will be that much more difficult.

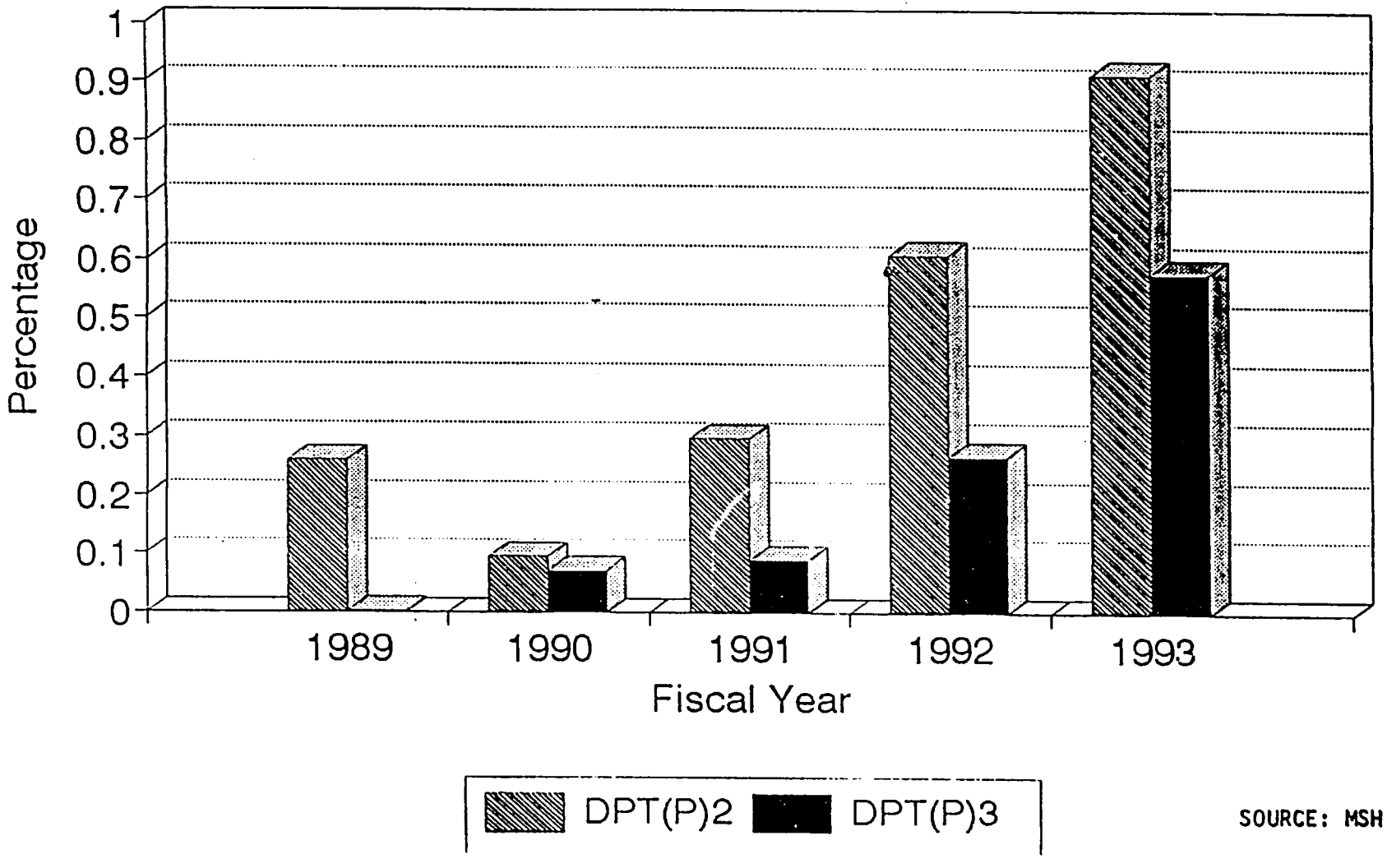
MSH's agreed upon responsibility is 101 districts in 24 provinces. The 1993 target population is approximately 212,000 under twos, and 198,000 women 5 - 45. Coverage rates are really not worth estimating because of difficulty and delays in establishing standardized reporting, highly imprecise knowledge of the population base in any area, lack of direct supervision of EPI activities, and difficulties in conducting surveys. Equally difficult is an approximation of total people vaccinated. MSH uses a rough computation of the <u>maximum</u> number of completely immunized by dividing the total number of BCG, DPT, polio and measles doses administered by 5 for the under twos children, and the total numbers of tetanus toxoid doses divided by three for women 5 - 45. One figure of performance is the percentage of the target reached. These figures annually run about 60 percent of target reached for childhood immunizations and 23 to 43 percent for women. When adjustments are made for disruptions such as those caused by delays in vaccine supply, inadequate security or bans, the effective percent accomplished against that planned rises to 55 - 85 percent for children and about 47 - 55 percent for women.

Figure 3 shows the steady increase in the second and third DPT and polio doses as a percentage of the first DPT-polio dose between 1989 and 1993 (1993 is estimated). In part, this reflects the more recent consistent geographic concentration and "catch - up" phenomenon following supply interruptions, delays caused by weather or security concerns, and bans of donor-assisted activities imposed for various lengths in districts because of theft or threat/injury to implementing personnel.

FIGURE - 3

DPT(P)2 and DPT(P)3 as % of DPT(P)1

all vaccinated children



SOURCE: MSH

B. International Medical Corps

The International Medical Corps initially received USAID support in the form of grants 1985-1991. On May 1, 1991, the grant format was replaced by a cooperative agreement. An amendment in July, 1992, required closure of the Peshawar-based training site and transfer of training activities into Afghanistan, establishment of a referral system, transfer of up to 20 (of 57 USAID-supported) clinics/hospitals to active Regional Health Administrations, participation (with MSH and MCI) in a combined procurement system, salary reductions for clinical and support staff totaling 50 percent by January 1, 1993 and support of 24 outreach EPI teams from 21 facilities. Amendment # 5, dated May 20, 1993, was a non-funded extension of the PACD to April 30, 1994. A primary reason for this extension was to permit the excellent IMC training staff to provide some technical assistance to the IPH training staff in Jalalabad (see below). The amendment contained an approved phase out plan which indicated that 12 facilities had been transferred to various RHAs, and support withdrawn from 12 facilities because of the redundancy exercise. Another 16 facilities had been declared redundant but had been resupplied through April, 1993. This left 17 clinics to receive USAID support no longer than through February 28, 1994, with close down of all USAID-funded activities by April 30, 1994. IMC will continue attempts to arrange for functioning RHAs or alternatives to take over as many of these as possible, and will try to help "privatizing" of the rest.

In early March, transfer of all training activities to Jalalabad was accomplished. Major training activities with the Institute of Public Health include conducting two Combined Mid-Level Continuing Education Courses and two refresher courses for field microscopist. IMC was dissuaded from its earlier plans to transfer its Peshawar-based training facilities to Qarabagh, north of Kabul, because of fighting in the area and USAID's refusal to fund the training in a proposed private hospital.

Because of limited funds and DMC's priorities in December, 1992, after long discussions with AVICEN, IMC withdrew its support of its EPI teams. The joint target plan for 1993 called for IMC to work in 20 districts in 9 widely separated provinces, in total having the potential to reach about 3 percent of the under twos in Afghanistan (about 1/6 the number reached by MSH). AVICEN had agreed to pick up as many of the vaccinators as possible, but did not have available funding or other resources in place when these vaccinators were let go. Few of these vaccinators were picked up by AVICEN. According to MSH, part of the problem may have been in AVICEN's reluctance for the former IMC teams to use the MSH VSFs which they had formerly drawn from unless AVICEN "approved" the facilities. MSH had its resources in place to complete its portion of the joint UNICEF, MOPH and donor-funded national EPI schedule, so could not hire them.

The IMC Purpose Level Monitoring System report of March, 1993 reports 217,105 fully immunized women and children from 1986 through 1992 when its program was no longer supported by IMC.

C. International Rescue Committee

The IRC immunization program was never funded by USAID, but is mentioned here because of USAID's other programs with IRC.

IRC vaccination teams began operation in 1989 with vaccinators trained by AVICEN. Later, IRC trained its own vaccinators because "AVICEN charged too much". Operations began in Paktika and spread to 31 districts in Logar, Paktika and Paktya with 17 mobile teams. There was only one vaccinator operating from a fixed facility in Logar. The VSF was located in Peshawar and supervision stemmed from that facility. About 50 percent of the vaccinators were natives of the districts in which they operated, so access to both children and females for the immunizations was not reported to be a problem. Dr. Maysam of IRC reported that in 1992, the teams reached 136 percent of their target for kids and 165 percent of the target for women. At the time of the IRC vaccination program, UNICEF was supplying the cold chain, vaccines, syringes and salary support. The 1993 joint plan calls for IRC to be the lead vaccinator in Logar and Paktya provinces, with the potential also of reaching about 3 percent of the under twos in the country. This about equalled IMC's target, but in much more limited and accessible areas.

D. Discussion

The EPI program lends itself well to donor assistance because of extensive world-wide experience; an extremely attractive cost-benefit ratio in providing unquestioned and long lasting health benefits at relatively small costs; standardization of training, equipment, cold chain techniques and maintenance, scheduling and reporting; and the centrality of UNICEF and WHO in procurement and technical backstopping. The good news is that most of the current implementing agents are marching to the same tune. The bad news is that it has taken so long to have this occur. Curiously, the Afghan beneficiaries probably have not directly suffered as much from this as have the donors and their implementors who have wasted untold time and money arguing amongst themselves or trying to agree on a common approach, an approach which has been used again and again world-wide. In spite of the squabbling, Afghans on both sides of the border have reached immunization levels never previously attained in Afghanistan. There unquestionably has been some degree of hyper-immunization, about as useful as serial vasectomies. Similarly, there may be pockets of people who theoretically could have been reached in spite of geography and warfare that haven't been reached, but that number must be eroding because of increased coordination which now includes the MOPH in

Afghanistan. The most significant group that still remains an important challenge is women of child bearing age, and even here, innovative methodologies (e.g., reaching pre-pubertal girls) and increasing numbers of female providers and MCH systems have the potential, over time, to provide greater coverage in this group.

As the largest USAID-supported EPI group, MSH has participated in the discussions and turf battles since it began EPI operations. Like most other groups, it has pointed fingers and had fingers pointed at it. There is no profit in pointing outside fingers; I have dwelt on the subject only to urge even greater continued cooperation in the future, whoever the players. To its great credit, MSH has been the lead agency in attempting to work within a counterpart framework with Afghan civil authorities, in or out of a "legitimate" government. Only now are many other organizations trying to emulate this approach. It also is the only group which simultaneously has mounted MCH and other PHC activities.

AVICEN is undertaking to enable its vaccinators to simultaneously provide additional primary health care interventions, distribution of ORS packets perhaps being one. Time did not permit further exploration of this plan which is being assisted by a VSO physician.

The 1993 MSH target population of 212,000 under twos is about 20 percent of the estimated total under two population. The target of over 198,000 women is approximately 16 percent of that population. Program costs for 1993, exclusive of technical assistance and associated costs, total $739,390, plus $191,000 in vaccines provided by UNICEF, or a total of $930,390.

Table 1 shows the MSH program costs of the basic MCH program, and the additive EPI component. The latter figure is slightly higher than it would be purely for EPI in that it contains minimal costs for medications for treatment of malaria and tuberculosis. The figures are exclusive of technical assistance and associated costs, and do not include the cost of UNICEF provided vaccines.

TABLE 1

MSH PROGRAM COSTS FOR MCH AND EPI BY FISCAL YEAR

FISCAL YEAR	MCH PROGRAM	EPI PROGRAM	TOTAL ($)
1990	136,154	719,984	856,138
1991	290,634	1,190,754	1,481,388
1992	485,681	1,107,266	1,592,947
1993	339,658	779,336	1,118,994
1994[a]	236,825	496,280	733,105
TOTAL	$1,488,952	$4,293,620	$5,782,572

a Estimates through April 30,1994

IV. LESSONS LEARNED

1. It is possible to conduct an extensive proactive curative and preventive health assistance program during armed conflicts by remote control from outside the country. It is not easy. By necessity, the program must be managed indirectly, with only tenuous control of human and material resources and a much lesser degree of monitoring and accountability expected in a more traditional foreign assistance program. Monitoring mechanisms can provide only snapshots of true events, enough to bring a measure of reassurance, but never enough to comfort. Reliable technical monitoring-cum-supervision is much more difficult to establish, not because there are insufficiently trained or inadequate numbers of Afghans willing to do it, not only because of security, but it is so labor intensive, time consuming and dangerous.

2. A single donor, USAID, with the proper implementing agent(s), can play the lead role in redirecting the orientation of health leadership from curative medicine to primary health care in a remarkably brief period. In Afghanistan this was done by identifying and being identified with emergent professional leadership, by example, by minimally investing in short but appropriate participant training (in this case Boston University short courses), and being willing initially to provide copious assistance for the curative requirements resulting from war.

3. Outsiders, Americans included, underrate the potential for the provision of high quality maternal and child health care in Afghanistan. Respect for cultural values is the sine qua non for all such efforts. A willingness to consider all possibilities and provide strong support for promising ones is the next step, one that the US health projects have taken. Mechanisms for much greater participation of women in this process have been developed, and with continuing support, may help revolutionize MCH. Men as providers should not be overlooked in this process. Similarly, MCH probably can not be optimally offered in the absence of availability of curative medical services for males.

4. The absence of a cohesive internal (Afghan) coordinating body for managing external assistance leaves the responsibility for donor coordination squarely with the donors and their implementors. This leaves the door open for both gaps and duplication (triplication, quadruplication) of efforts, Paraphrasing Donne, "No donor is an island". The requirements for assistance in a country like Afghanistan are staggering. There is enough work for everyone, and little room for wrangling. Should a situation require cross-border assistance in the future, the US should require coordination of its implementors, and request it from its partners, from the beginning.

5. Issues of redundancy and sustainability of the health system can be dealt with unilaterally by one donor, but it takes conviction and organizational courage. The Health Development Officer of the Office of Afghan Field Operations was willing to reduce duplication or redundancy of facilities by forcing closure or relocation from better served to lesser served areas. Similarly, he forced reductions in salary levels in order to more nearly approach post-conflict indigenous support levels. This had the (intended) side effect of introducing fee-for-service and other forms of cost sharing, perhaps more supportable by the Afghan MOPH as donor resources tumble. Neither of these were popular steps, but both seemed necessary, and he received organizational backup. One can debate his definitions of redundancy and degree of salary reductions, but not his sincerity nor his resolve. Perhaps neither of these painful steps would have been necessary had there been better donor/implementor coordination earlier.

6. Household surveys conducted by MSH and experience resulting from USAID-induced requirements for income generation in its project activities fairly conclusively demonstrate that rural Afghans will pay for health services.

7. Creation of one-woman "posts" (where the MCHO is not physically part of a health facility with other staff) has a high rate of failure and is no longer supported. Assignment of more than one woman to a facility greatly improves retention, although retention has occurred with one woman in a facility in instances where her spouse is also employed in the clinic. Over 900 male BHWs are functioning independently, some for long periods.

8. The flexibility afforded by a Cooperative Agreement compared to a contract makes it the preferred mechanism in a situation subject to rapid change as has been the case in Afghanistan. USAID and the implementor both are better served.

V. SUGGESTIONS FOR DONOR-ASSISTED FOLLOW-UP

In March, 1993 when the Mission wrote its Afghanistan Strategy, it fully expected to design a follow-on project focussing on MCH and EPI. At the time of this evaluation, the Mission was awaiting word from Washington about future expectations. The following suggestions are made in the event A.I.D. or another donor should consider funding a project or activity focused on EPI or upon the more inclusive PHC category of MCH. The suggestions are in keeping with the strategy document, and in fact are variations of those themes. There are many options a donor might consider, including the following:

A. Option 1- No program support until conflict resolution

This approach assumes a donor would be unwilling to mount a cross-border program, but would wait until the level of war-like conflicts would permit a more traditional program. The advantages are that efficiency of program support with this option would be higher than by operating cross-border. The immense disadvantage is that all or most all traces of ongoing programs currently supported would have disappeared, and it would be necessary to rebuild it all nearly from scratch.

B. Option 2- Support the current EPI program

An underlying reason for considering EPI first is that EPI is a highly cost-effective component of PHC, has already some degree of national coverage and currently is the most coordinated of all health programs in Afghanistan. The US-supported EPI program is in place and intact and would need not interrupt its activities if financial support continues. It lends itself easily to expansion and contraction. To support the program at current levels would require funding for all the EPI personnel currently supported by MSH, including a high level expatriate advisor and a technical staff of 2-3. The list appears in Chapter III above. Additionally, the PMD component, consisting of one director, a deputy, 2 field operations personnel and two trainers should be funded, but should move inside Afghanistan and draw its vaccine and other equipment from MSH, AVICEN or MOPH VSFs.

Assumptions here are that the current national level of urban vaccination is sufficient (which it is almost certainly not) and that coverage of all the areas currently covered (and their populations) will be continued by current, new or additional donor support. Since all or nearly all of the cross-border programs are for rural areas, a major question is the current level of urban coverage, presumably being provided now by the Afghanistan government.

If the urban population is not adequately covered, and if it represents the reported 20 percent of the total population, the donors may be requested to help provide coverage for some or all of the urban population. Any EPI support should attempt to establish as many fixed points as possible in order to integrate EPI into general health services.

C. Option 3- Support the current MCH program

The current MCH program (Chapter II) focuses largely on training and deploying female providers and promoters at multiple levels in the PHC pyramid, specifically the midlevel MCHO, the VHS and the FHW, usually a dai. Because of traditional and cultural reasons, training these categories have little chance of centralization; and perhaps, not even regionalization. To gain widespread coverage with these categories, particularly MCHOs, may require provincial-level or similar training programs. Donors other than the US are not as likely to pick up support of the existing US-assisted program simply because experience with it has been so limited. To date, Afghan receptivity to the whole concept of female-provided MCH has varied considerably. The Northern RHA has appeared most receptive, and would be the first area to consider supporting. Some receptivity has been shown by the Central RHA, and might be the next logical area for consideration of support. While there has been receptivity in the eastern bordering states, there has been no real emergence of RHAs, which to date has been a requirement for USAID support. Nonetheless, because of the receptivity and the large populations from Paktika northward, this would be the next recommended area. The South and Southwest Afghanistan RHA has not provided continuing support for previous attempts to establish MCH facilities, and it would be well down on the list for support. For the next several years, the most southern provinces do not appear fruitful because of sparse populations and poppy culture.

It likely would be possible to conduct FHW training in each geographic area (except the south) if sufficient MCH clinics can be established in the areas to serve as training sites. The fastest way to accomplish this would be to reestablish the three-week MCH refresher or so-called inservice MCH course previously given in Peshawar in as many of the foregoing regions as possible, and attempt to train all female providers available in any facility supported by the MOPH or any donor. With some modification, it might be possible to add instruction for VHS training to these same individuals. Major constraints, as already outlined, will be to recruit adequate numbers of both female providers and trainers. The IPH training staff in Jalalabad could become master trainers for the refresher course.

Transferring the training of MCHOs to other regions appears that it will be very difficult because of requirements for female trainers, living accommodations for those students without relatives in the training area and the availability of sufficient clinical training facilities. The current IPH MCHO training personnel might be induced to become master trainers. If female trainers could be recruited for existing IPH training centers in Takhar and Balkh, the existing IPH personnel in those centers, if retained, could provide technical and administrative support. Similarly, the IPH technical staff in Kabul should be maintained, not only for training, but for very important interface with other MOPH personnel.

There have been some indications that the strong regional civil administrations which developed during the Russian occupation and subsequent communist government may be weakening. If that is the case, the criteria for donor support may be modified more to follow provincial rather than regional administrations. While this is conjectural, in any of the above scenarios consideration should be given also to maintaining the Jalalabad training center because it has had the only internal experience training MCHOs, and has a plethora of excellent training facilities available, including the AOGH and the MMC. Additionally, one of the 5 currently deployed MCHOs has been providing outreach training, and is an excellent role model.

In the establishment or continuation of any of the above training programs, including the 3 week refresher, decisions will have to be taken on which elements of MCH should be emphasized. After a standardized PHC overview, it is quite likely that training for one area might give additional emphasis to treatment of diarrheal diseases, another more to acute respiratory diseases, another to anemias of pregnancy, etc. Sorting this all out would be part of the challenge.

D. **Option 4-** Support both above programs in their entirety, or "defensible" pieces of each.

Because of progress made to date in both these vital programs, the ideal continuation would support both the foregoing programs in their entirety, keeping options open to further expand MCH and EPI services. A next choice might be to support both the above without considering expansion. Third, fourth and endless variations of this option, depending on the availability of funds, would be to support one or both programs in more limited geographic areas, perhaps down to one region or even one or several provinces. At the provincial area of support, the health benefits would be minimal and the assistance might be viewed as a "pilot

project". If this were the case, it would be in danger of going the way of many pilot projects, littering the landscape and the literature, but doing little to improve health status which the host country can maintain.

SCOPE OF WORK FOR THE EVALUATION OF THE HEALTH SECTOR SUPPORT PROJECT (HSSP) AND THE PVO SUPPORT PROJECT (PSP)

I. ACTIVITIES TO BE EVALUATED

Project Title:	Health Sector Support Project (HSSP) and PVO Support Project-(PSP)
Project Number:	HSSP (306-0203) and PSP (306-0211)
LOP Funding:	HSSP - U.S. $69 million PSP - U.S. $37 million
Project Authorization:	HSSP - August 8, 1986 PSP - May 16, 1990
PACD:	HSSP - June 30, 1994 PSP - June 30, 1994

II. PURPOSE OF THE EVALUATION

The purpose of this evaluation is to assess two specific components of the present O/AID/Rep Health portfolio, identifying activities undertaken to date, achievements and constraints.

The evaluation will focus only on those aspects relevant to the Mission's new strategy, i.e., Maternal and Child Health Care (MCH) and Expanded Program of Immunization (EPI). It will cover the MCH and EPI components of Management Sciences for Health (MSH), the primary O/AID/Rep implementor for the HSSP, and Mercy Corps International (MCI), International Medical Corps (IMC) and International Rescue Committee (IRC), the three American NGOs funded through the PVO Support Project. The primary focus will be MSH's experience in MCH and EPI.

III. BACKGROUND

The O/AID Rep Health Portfolio consists of the Health Sector Support Project (HSSP) (306-0203) implemented by Management Sciences for Health (MSH), and three activities funded through the PVO Support Project (306-0211) which are implemented by the

American NGOs: International Medical Corps (IMC); Mercy Corps International (MCI); and the International Rescue Committee (IRC). Presently, two Afghan NGOs are funded through the IRC activity, as sub-grantees.

The primary focus of the O/AID/Rep's cross-border humanitarian assistance program has been the health, education and agriculture sectors, with additional efforts in rural reconstruction and relief assistance. All program components continue to be implemented cross-border by contractors and grantees, in collaboration with Afghans, due to political instability, continued conflict and lack of security.

In late 1986, the initial purpose of the O/AID/Rep's health program, which is presently implemented through four Cooperative Agreements, was to provide basic health care to Afghans, through training of health workers, the establishment and support of clinics and hospitals and support of basic health workers.

At present, the O/AID/Rep is the largest donor to health delivery in rural Afghanistan and its program supports over 1,500 mainly curative health facilities, many of which are one-person health posts, with provision of medical supplies. To staff these facilities, located in the rural areas of all 29 provinces of Afghanistan, it also supports approximately 4,000 health workers (2% female).

MSH, the primary O/AID/Rep implementor for HSSP, coordinated activities with the former Ministry of Public Health of the Afghan Interim Government (MOPH/AIG) and Regional Health Administrations (RHAs). These RHAs, located in the North, Central, East and West sections of the country were established and trained to develop and institutionalize pyramidal health care delivery systems.

The O/AID/Rep health programs have trained over 3,000 Afghans - the majority in basic health and mid-level health care, but also in immunization and MCH. These training programs have additionally provided refresher training/continuing education to over 2,800 health workers.

In this mainly curative-focused rural health system supported by the O/AID/Rep, in which an initial need was to treat war injuries, a disproportionate number of men are being served. This fact, along with cultural biases and constraints, which often precludes women from being treated by male health workers, severely limits women's access to health care. Following evaluations done in 1989, 1990 and 1992, projects were redesigned to emphasize, among other things, preventive health care with emphasis on services for women and children.

In the last several years, modest success has been achieved in

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redirecting services to infants, children and women: even though approximately 36% of services are now provided to females (over 5 years of age), roughly only 18% of services go to children under 5 and infants. Maternal and Child health care services have been established in areas where there is greater receptivity, and immunization program activities have been implemented in 25 of the 29 provinces of the country.

In 1991, MSH initiated an MCH program which now supports 42 MCH facilities, staffed mainly by female health providers. Females and children are provided important preventive and curative services at these MCH facilities, which include pre- and post-natal services, family planning, oral rehydration therapy (ORT), health education, nutrition and treatments for malaria, acute respiratory infections, diarrhea and other diseases. Training of dais (traditional birth attendants) is another important service provided by MCH facility staff.

MSH has established 63 MCH facilities to date, of which 42 are currently active. Of these, 35 are located in the north and central regions of Afghanistan, indicating a willingness in these two regions to implement services for women and children provided by women. MCI, working in eight Southwest provinces, initiated an MCH Program to establish MCH centers with USAID funds. In a two year period of time, it met with limited success, establishing only 3 centers, one of which was canceled. A major causative factor was the lack of trained female health providers.

The International Rescue Committee (IRC) also supported two MCH projects. AID helped support the Afghan Obstetrics and Gynecological Hospital (AOGH) in Pakistan for several years. The AOGH provided MCH clinic services as well as hospital services for Afghan women. The AOGH moved their operations inside Afghanistan in February 1993, and a new proposal for USAID funding has not been received. Another MCH project is implemented by the Mujahid Emergency Medical Center (MMC). Located in Nangarhar province, this program supports an MCH clinic where MCH services and family training in health education are delivered by Afghan female practitioners, along with home visiting services which provide health education in the home.

In 1988, MSH instituted their Expanded Program for Immunization (EPI), which currently supports over 295 vaccinators providing the six major immunizations, targeting diphtheria, pertussis, neonatal tetanus, measles, polio and tuberculosis. These vaccinators operate in 187 districts in 25 Afghan provinces. Nine vaccine storage facilities have been established inside Afghanistan. MSH's Afghan counterparts have trained and fielded 298 EPI personnel, and refresher training is routinely conducted for all vaccinators plus immunization and cold chain technicians.

With the fall of the communist regime in April 1992, the

Mission's strategy for the Afghan cross-border program entered a new phase - that of renewal, which focuses in part on the urgent social needs of the country. With the reduced funding levels for FY94, the Mission identified two major needs on which to focus the new health strategy: the Expanded Program for Immunization (EPI) and Maternal Child Health (MCH) services provided by female health care workers. All other USAID health program activities not directly supportive of these two components will be phased out by the end of FY94.

IV. STATEMENT OF WORK

The evaluation will cover only two aspects - MCH and EPI activities - that are found in the health portfolio, implemented by the following four entities: MSH, MCI, IMC and IRC-Health. The primary focus will be MSH's experiences with MCH and EPI. The evaluator shall consider and assess the following concerns:

* Achievements against Project objectives;
* Major constraints to project implementation;
* Lessons learned.

Specifically, s/he shall consider the following program concerns:

A. MANAGEMENT SCIENCES FOR HEALTH (MSH)

1. MCH Program Activities:

a. What is the demand structure for MCH activities in Afghanistan? To what extent does it differ by regions?

b. To what extent has the MCH program achieved its objectives of establishing MCH centers, staffing by female health providers and expanding availability of MCH services?

c. How has the quality and quantity of the MCH services been measured? What data is available in regards to: numbers of females/children seen at MCH centers; types of health problems treated and provision of other types MCH services to women and children?

d. How successful has the training of dais by female staff at the MCH centers been? How was the success measured? What problems were encountered?

e. How many Volunteer Health Sister (VHS) training sites have been established? How many VHSs have been trained? What have been the successes and problems encountered?

2. EPI Program:

a. To what extent has the EPI program achieved its objectives in providing EPI services in their target areas? What have been the successes and problems encountered?

b. How has the quality and quantity of the EPI services been measured? What data is available in regards to numbers of females and children immunized?

3. Training of Female Professional Personnel:

a. MCHO Course. To what extent has the objectives for the course been achieved? What have been the successes and problems encountered in this program? What are the plans for expansion to other areas?

b. Training/Upgrading Female Staff for MCH Centers. By whom, by what means and where has this training been done? How has the effectiveness of the courses been measured? What have been the problems encountered?

c. Training of Trainers Courses. By whom, for whom and by what means have these courses been conducted? How has the effectiveness been measured? What have been the problems encountered?

d. The Institute of Public Health (IPH). As the major training entity, what are the strengths and weaknesses of the IPH in regards to provision of training for female health providers or trainers? Of the present IPH staff, how many are female? Which personnel would actually be needed to manage and conduct: 1) female health worker training; and 2) EPI personnel training?

B. MERCY CORPS INTERNATIONAL (MCI).

1. MCH Program Activities:

a. To what extent has the MCH program achieved its objectives in establishing MCH centers, staffing by female health providers and expanding availability of MCH services?

b. How has the quality and quantity of the MCH services been measured? What data is available in regards to: numbers of females/children seen at MCH centers; types of health problems treated and provision of other types MCH services to women and children?

C. INTERNATIONAL RESCUE COMMITTEE (IRC) - HEALTH.

1. Mujahid Emergency Medical Center (MMC).

a. To what extent has the MCH program achieved its objectives in establishing an MCH center, staffed by female health providers and expanding availability of MCH services?

b. How has the quality and quantity of the MCH services been measured? What data is available in regards to: numbers of females/children seen at the MCH clinic; types of health problems treated and provision of other types MCH services to women and children?

c. How successful has the home-visiting component of the program been in providing health education in the home by female health workers? What have been the problems encountered?

d. To what extent has the EPI program achieved its objectives in providing EPI services to the clinic target population? What have been the successes and problems encountered?

D. INTERNATIONAL MEDICAL CORPS (IMC).

1. To what extent had the EPI program achieved its objectives in providing EPI services in their target areas? What were the successes and problems encountered?

2. How were the quality and quantity of the EPI services measured? What data is available in regards to numbers of females and children immunized?

E. OTHER NON-USAID FUNDED EPI/MCH/FEMALE TRAINING PROGRAMS.

In addition to USAID-funded activities, the consultant will also look at the following activities in order to assess their general merits as alternative strategies - specifically other EPI or MCH programs and other female health worker training methodologies. These non-USAID-funded programs will include, but not be limited to: 1) MCI's EPI and female health worker training programs; 2) AOGH's MCH and EPI programs; and 3) the Afghan Vaccination and Immunization Center (AVICEN) EPI program.

F. GENERAL QUESTIONS.

The following questions should be addressed for all of the above activities:

1. Monitoring and evaluation. How effective and useful are project monitoring and evaluations in the field in providing project managers with progress/problem feedback and qualitative data? Have technical evaluations been done in the field? If so, what were the results?

2. Constraints and Opportunities. Identify the constraints and opportunities that have either impeded or enhanced program implementation. How many of the constraints still exist? What are some options for overcoming the constraints?

3. Administration and Logistics. Given the cross-border nature of all programs, what system is in place to utilize Afghan entities to implement, administer, manage and supply the program and its activities? What have been the successes and problems encountered?

4. Beneficiaries. How well were the beneficiaries of the program reached? What system is in place or is not in place to ascertain the extent to which they have been reached?

5. Women in development. Compared to men: 1) how were the interests and roles of women taken into account in planning and implementing the program; 2) in what ways did women participate in the process; and 3) how were the interests and roles of women taken into account when evaluations were conducted?

6. Sustainability. Sustainability refers to the capability of a program to financially maintain services when the project is completed or when funding is diminished or withdrawn. Are there any on-going activities which contribute to sustainability of the various programs? What activities could be utilized to support sustainability?

7. Lessons Learned. What were the lessons learned in implementing the MCH and/or EPI program(s)?

8. Management. Comment briefly on any aspects regarding PVO implementation that contribute to or significantly detract from potential effectiveness.

G. RECOMMENDATIONS.

Based on the field work and the information collected, what are the recommendations for effective implementation of an EPI program and an MCH program?

V. METHODS, PROCEDURES AND TIMING

The consultant shall work under the overall guidance of Douglas Palmer, Health Development Officer, USAID, Islamabad, Pakistan. He/she should analyze key documents, including: 1) the 1989, 1990 and 1992 PSP and/or HSSP evaluations; 2) the Cooperative Agreements between the O/AID/Rep and MSH, IMC, MCI and IRC; 3) the MSH FY 1993 work plan.

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The consultant must interview all key O/AID/Rep, MSH, MCI, IMC and IRC employees. He/she must also interview the former MOPH/AIG, Regional Health Committee Representatives (based in Peshawar), relevant NGOs (based both in Peshawar and Quetta), and UN Agencies (particularly UNICEF and WHO) to get a full picture of the existing cross-border health program.

The consultant's work will be conducted over a period of five weeks beginning September 10, 1993 through October 15, 1993. The consultant will work a six-day work week and holidays.

At the beginning of the evaluation period, the consultant shall spend two to three days in Islamabad interviewing the concerned USAID officials and studying the basic documents in order to reach common agreement among themselves on specifics of the task and how to proceed. The following three and one half weeks will be spent in Peshawar and Quetta carrying out the evaluation of the HSSP and PSP projects.

After completion of field work, the consultant shall return to Islamabad for debriefing and the finalization of reports. All final reports shall be submitted to the Project Officer at the end of the fifth week, prior to the departure of the consultant from Pakistan. Written reports and debriefings will be as outlined in the tentative schedule.

Tentative Schedule:

SEP 10	: Arrival in Pakistan
SEP 11	: Review of background materials
SEP 12-13	: Meetings with USAID in Islamabad
SEP 14-30	: Field work (Quetta and Peshawar)
OCT 1-5	: Further consultation and report writing in Islamabad
OCT 5	: Submit drafts of 3 reports (executive summary, major findings)
OCT 7	: Debriefing with Project Committee
OCT 14	: Final debriefing and submission of reports
OCT 15	: Departure from Pakistan

The O/AID/Rep will attempt to provide local surface transportation for the consultant and secretarial assistance for the final reports. He/she should bring an auxiliary portable calculator and a Personal Computer/Word Processor (preferably

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Word Perfect 5.1) to reduce pressure on the O/AID/Rep staff and equipment.

VI. THE COMPOSITION OF THE EVALUATION TEAM

The evaluation will be conducted by one person who shall possess extensive experience with AID Health Portfolio evaluations and/or Health Project Planning and should have a strong public health background with expertise in implementation and evaluation of maternal and child health care and immunization activities.

VII. REPORTING REQUIREMENTS

The consultant is required to submit three written reports:

A. Evaluation report.

The evaluation report must adequately address all areas contained in the scope of work (Section IV). It should include:

1. Data sheet;
2. Executive Summary (sample format to be provided by USAID) stating the findings, conclusions and recommendations;
3. Table of Contents;
4. Body of the Report (which includes a brief project description, the environment in which the project operates, a statement of the methodology used, major findings, conclusions and recommendations, lessons learned, achievement of project purposes and impact on project beneficiaries); and
5. Annexes.
6. The entire report (exclusive of annexes) should not exceed 50 pages.

Annexes to be attached to the final report include:

1. The evaluation scope of work;
2. A list of persons consulted;
3. Background supplemental material useful for a fuller understanding of the report; and
4. An annotated bibliography of significant research reports/studies consulted.

The report shall clearly define major findings, conclusions and recommendations and should also explicitly state any lessons learned.

In making recommendations, the consultant must consider that the current Mission strategy is limited to cross-border operations and will only focus on MCH and EPI services. The recommendations

should also take note that the PACDs of current projects will not be extended and further efforts must fit into the current Mission strategy.

B. Background Report.

The consultant will also provide a background paper which will describe:

1. AID's experience in EPI and MCH to date;
2. A description of geographic areas in which further AID interventions would be feasible; and
3. A description of status, roles and relationships of the principle Afghan counterpart entities engaged in EPI and MCH activities currently in Afghanistan. These entities include: the Regional Health Administrations (RHAs), the former Ministry of Public Health of the Afghan Interim Government (MOPH/AIG) and the Institute of Public Health (IPH).

C. Technical Analysis Report.

Based on the fieldwork undertaken, the consultant will prepare a technical analysis that the Mission will use in the process of designing the Maternal and Child Health Services project. The technical analysis will be expected to answer the following questions:

1. What are different alternative approaches which could be used to implement an MCH Program (establishing centers and delivery of MCH services) in the North and Central regions of Afghanistan? Which approach would be recommended as the most feasible, suitable and cost effective? Justify.

2. What are different alternative approaches which could be used to implement an EPI Program, both in rural and urban areas of Afghanistan? Which approach would be recommended as the most feasible, suitable and cost effective for each? Justify.

3. What are different alternative approaches which could be used to train/upgrade the various levels of female health providers proposed in this project: MCHO (midlevel) worker; female health personnel to work in the MCH centers; dais (traditional birth attendants); and village level health workers? Can the required number of candidates for each level be trained in a timely manner? Which approach (for each level) would be the most feasible, suitable and cost-effective? Justify.

4. Given the cross-border nature of the proposed MCH and EPI programs, what are the different alternative approaches which could be used to implement, administer, manage and supply these programs (the functions presently being performed by the RHAs and former MOPH/AIG)? Which approach (for each program) would be the most feasible, suitable and cost-effective? Justify.

5. What will be the operational relationship with the MOPH/GISA in Kabul?

6. In order to effectively measure the impact and quality of both the EPI and MCH programs, what are the different alternative approaches which could be utilized in establishing a technical monitoring unit for this purpose? Which approach would be the most feasible, suitable and cost-effective? Justify.

For further guidance, the contractor may consult the AID Handbook III section dealing with technical analysis of a project.

The consultant will submit 10 copies of the final reports to Mr. Douglas Palmer, Health Development Officer, prior to departure from Islamabad.

APPENDIX B

PERSONS CONTACTED

USAID Mission to Pakistan and Afghanistan

John S. Blackton, Director
Basharat Ali, Head PDM
Mike Hauben, Chief PDM/PRO
Roger Helms, DC & A Unit
Babar Hussain, Assistant Health Officer
Mella Aalto Leiter, BSN, Assistant Health Officer
Douglas Palmer, Health Development Officer

Afghanistan Obstetrics and Gynecology Hospital

Hermione Youngs, Hospital Manager
Jill Hoffmann, Liaison Officer
Dr. Julia McEwan, Medical Director

Afghanistan Vaccination and Immunisation Centre

Dr. Alistair McEwan, Medical Advisor
Dominic O'Loughlin, Data Specialist

Bakhtar Clinic (Private Clinic in Quetta with MCH Component)

Dr. Nazefa, OB/GYN physician

European Economic Community

Dr. Willie Demeyer, Representative

International Medical Corps

Steven Tomlin, Field Director
Dr. Anwarul Haq, Deputy Director

International Rescue Committee

Ariel Ahart, Acting Coordinator
Dr. Maysam, EPI Coordinator

Ministry of Public Health

Dr. Shah Agha, MCH Director, VHS Training
Dr. Belqees, Deputy and VHS Trainer
Mrs. Zarghona, VHS Trainer

Management Sciences for Health

Dr. William D. Oldham, Chief of Party
Dr. Ahmadullah Ahmadzai, Director MCH
Vim Dias, Procurement and Supply Management Advisor
Mary Gasper, Finance Officer
Mr. Yusef Ghaznavi, Senior Program Specialist
Dr. Hasibullah, VHS Program Coordinator and Evaluator
Dr. Paul Ickx, Communicable Diseases and EPI Advisor
Richard Johnson, Training Advisor
Mr. Karim, Administrator,Training Division
Dr. Sabir Latifa, EPI
Dr. Laurance Lamounier, Field Operations Advisor
Dr. Obaidullah, EPI
Mrs. Razia, MCHO Trainer
Dr. Diana Silimperi, MSH Headquarters Staff VHS Advisor
Dr. Mubarak Shah, Deputy Director, Training Division

Mercy Corps International

Donald E. Bradford, Country Director
Thomas H. Hemphill, Asia Regional Director
Dr. M. Imam, Medical Division Head

Mujahid Emergency Medical Center

Dr. A. Reha, Director

Shuhada Clinic (Private MCH Clinic in Quetta)

Dr. Sima, Director

Swedish Committee for Afghanistan

Dr. Inger Anderrson, Medical Advisor
Ghulam Farooq Wardak, Health Department Director

United Nations Children's Fund

Alan Brody, Deputy Director
Dr. Louis Fonseca, EPI Officer

World Health Organization

Dr. M. Jama, Health Advisor for Kabul

APPENDIX C

MAJOR DOCUMENTS REVIEWED

Agency Coordinating Body for Afghan Relief

Minutes of the Forum. Peshawar; September 2, 1993.

Afghanistan Vaccination and Immunization Center

Functional Overview of the National EPI Information Exchange System - NEISS. Pehawar. August, 1993.

Summary of the Action Plan for the Mass Campaign of Immunization against Measles Targetting under 2 Children in Kabul City. Kabul. September 1993. (Published in conjnction with UNICEF and the Ministry of Public Health).

International Medical Corps (IMC)

IMC Agreement No. 306-0211-A-00-1206-00, May 1, 1991

Amendment 2 to above, July 19, 1992

Amendment 5 to above, May 20, 1993

Quarterly Reports October 1, 1992 - December 31, 1992

January 1, 1993 - March 30, 1993

International Rescue Committee

Cooperative Agreement No. 306-0201-A-00-9826-00, July 19, 1989

Aghan Obstetrics and Gynaecology Hospiatal Evaluation Report, Ugland L; Leiter MA; Irwin P; and Jelich D. Peshawar, March 20, 1992

Data on Women and Children Beneficiaries for FY 1992. Memo by Ariel Ahart, Peshawar. November 17, 1992

The International Rescue Committee Program for Afghans Annual Report 1992. Peshawar. June, 1993.

Medical PVO Co-Financing Program. 1992 Annual Report

Quarterly Narrative Report to the Office of the AID Representative Medical PVO Co-Financing Program. (January 1 - March 30, 1993

Quarterly Narrative Report to the Office of the AID Representative Medical PVO Co-Financing Program. (April 1 - June 30, 1993)

Monitoring Mission to Jalalabad, Ningarhar. A. Ghias M. Safi, Peshawar. July 15, 1993.

International Science and Technology Institute, Inc. (ISTI)

Afghanistan Health Sector Support Project Assessment. Brown V, Hunte P, Loken K, Stockman C. Washington, D.C., August, 1988.

Management Sciences For Health (All published in Peshawar)

Cooperative Agreement No. 306-0203-A-00-6014-00, Islamabad, dated September 22, 1986. Also reviewed several amendments

Demographic and Health Household Survey in Afghanistan/Takhar Province. Tawfik Y, Bahaand O, Saleh B; March, 1992.

Workplan for Project Year 7, FY-93 (1 October 1992 through 30 September 1993).

Afghanistan Health Sector Support Project Quarterly Reports:

July 1 - September 30 1992

October 1 - December 31 1992

January 1 - March 31 1993

April 1 - June 30 1992

Summary Trip Report to Herat. Paul Ickx; Peshawar. May 31, 1993.

VHS, FHW and MCHO Programs Assessment Report. Drs. Hasibullah and Shah Agha; May-June, 1993.

Planned Target Population for EPI per District in Afghanistan for 1993 (this is an undated and jointly prepared document by the Task Force for EPI)

Demobilization Plan undated

Managing Health Systems in Developing Countries. Ronald W. O'Connor, Editor; Lexington, Mass. 1980

Mercy Corps International (MCI)

Cooperative Agreement dated June 1, 1991, and amendments

M.C.I. Draft Outline for Health Proposal for 1993/1994, April 6, 1993

Fifth and Final Revised Phase-out Plan, Memo by Imam, G. Jenkins and D. Bradford, Quetta, September 15, 1993

Quarterly Reports October 1 - December 31, 1992.

January 1 - March 31, 1993

April 1 - June 30, 1993

Mujahid Emergency Medical Center

MMC/Family Training Program Activities Report for IRC from March 15th - June 30th, 1993. Peshawar. August 7, 1993

MMC Activities Reports, July and August, 1993.

USAID Mission for Pakistan and Afghanistan. (Includes various predecessor administrative arrangemnts).

Project Review: Afghanistan Health Sector Support Project (HSSP). Shutt M, Jordan M, Palmer D, Zopf, L. Islamabad, February, 1990.

Afghanistans's Population Inside and Out. Thomas H. Eighmy, May, 1990.

Afghanistan Health Portfolio Evaluation. Shutt M, Hunte P, Sewell J. Peshawar, February, 1992.

A.I.D. Project Evaluation Summary, Health Sector Support Project and PVO

Sector Support. March 9, 1992.

Afghanistan Strategy. March, 1993.

Report of Health Portfolio Implementation Review. Sara Fassett; May 31, 1993.

Practices and Problems of Female Health/Medical Technicians in NWFP. Faisel A, Khan PA, Noreen A; Islamabad, July, 1993.

Sitrep Material: UNOCHA Seminar (September 12, 1993) on Health for Afghanistan. Memo by Douglas Palmer, Islamabad, September 13, 1993.

United Nations

Office for Rehabilitation Strategy for Afghanistan

Plan of Action for Immediate Rehabilitation of the Health System in Afghanistan, July 1993 - June 1995. Islamabad, June, 1993.

World Health Organization

Masterplan for Rehabilitation and Reconstruction of the Health System in Afghanistan. Geneva. May, 1991.
(Prepared in Consultation between WHO and the Government of the Republic of Afghanistan and between WHO and the Afghanistan Interim Government)

United Nations Children's Fund

Report on EPI Visit to Shindand Luiz Fonseca, May 30, 1993.