A.I.D. EVALUATION SUMMARY PART I

(BEFORE FILLING OUT THIS FORM, READ THE ATTACHED INSTRUCTIONS)

PD-ABM-526

98433

IDENTIFICATION DATA

A. REPORTING AID UNIT: Office of AID Representative (Mission or AID/W Office)

(ES#

B. WAS EVALUATION SCHEDULED IN CURRENT FY ANNUAL EVALUATION PLAN? yes [X] slipped [ ] added [ ]

Eval Plan Submission Date: FY 87 Q 4

C. EVALUATION TIMING interim [X] final [ ] ex post [ ] other [ ]

D. ACTIVITY OR ACTIVITIES EVALUATED (List the following information for project(s) or program(s) evaluated; if not applicable, list title and date of the evaluation report)

Project #	Project/Program Title (or title & date of evaluation report)	First PROAG or equivalent (FY)	Most recent PACD (mo/yr)	Planned LOP Cost ('000)	Amount Obligated to Date ('000)
398-0290	Afghanistan PVO Support Project	N/A	12/87	$ 2,257	2,257
306-0201	PVO Co-financing Project: Evaluation of AID, REP-Assisted Private Voluntary Organizations (PVOs) Providing Health-related Assistance to War-Affected Afghans		3/92	$20,000	8,097

ACTIONS

E. ACTION DECISIONS APPROVED BY MISSION OR AID/W OFFICE DIRECTOR

Action(s) Required	Name of officer responsible for Action	Date Action to be Completed
1. Provide direction, funding and support for CMC. (Coordination of Medical Committees, an umbrella organization best suited to pursue the evaluation's technical training recommendations.	Health Officer	On-going
2. Organize a case study in which 3 PVO-trained medics work directly for AHC clinics.	Health Officer	Dec 1987
3. Assist PVOs in their efforts to send medical teams inside to evaluate effectiveness of training and service delivery.	Health Officer	On-going
4. Encourage coordination between MSH and PVOs.	Health Officer	On-going
5. Encourage PVOs to recruit ex-pat staff for minimum of 6 month tours to ensure continuity in training.	Health Officer	On-going

(Attach extra sheet if necessary)

APPROVALS

F. DATE OF MISSION OR AID/W OFFICE REVIEW OF EVALUATION: mo___ day___ yr___

G. APPROVALS OF EVALUATION SUMMARY AND ACTION DECISIONS:

	Project/Program Officer	Representative of Borrower/Grantee	Evaluation Officer	Mission or AID/W Office Director
Signature	C. Palma			
Typed Name	Carole Scherrer-Palma	N/A	John Gunning	Larry K. Crandall
Date:	10/28/87		10/28/87	10/28/87

H. EVALUATION ABSTRACT (do not exceed the space provided)

The focus of this evaluation is upon seven PVOs (Private Voluntary Organizations) based in Pakistan who are training Afghan medics and also are supporting networks of health facilities within Afghanistan. These organizations are funded by the PVO Co-Financing project. The Office of AID/REP called for this evaluation in order to assess progress made to date in: (1) project effectiveness in Pakistan and AFghanistan, (2) PVO monitoring and evaluation and (3) PVO collaboration and coordination. Specific field methodology included: (a) review of PVO files/project documents, (b) key informant interviewing and (c) participant observation at training facilities, clinics and hospitals in Pakistan.

The major findings and conclusions are:

1. PVOs can train qualified mid-level health personnel to work inside Afghanistan.

2. A key to improving project effectiveness in both Pakistan-based training activities and cross-border health care delivery with Afghanistan is PVO coordination. AID/REP should support the CMC(Coordination of Medical Committees) which is made up of PVOs reviewed here and others.

3. PVO coordination is necessary in curriculum development, standardization of treatment protocols,and crucial formation of multi-organizations and multi-national evaluation teams to monitor health care delivery inside Afghanistan.

The evaluators noted the following lessons:

1. In view of current Afghanistan health care needs, PVO training programs are appropriate for "medic" personnel with limited previous formal education. This is accomplished best with instructors remaining for six months or more.

2. PVOs furnish a necessary diversity and commitment. Their multi-national constituencies provide a broader base of support in both funding and human resource expertise.

ABSTRACT

I. EVALUATION COSTS

1. Evaluation Team

Name	Affiliation	Contract Number OR TDY Person Days	Contract Cost OR TDY Cost (US$)	Source of Funds
Sharon Benoliel	AID/W	21	12,000	O/AID/REP
Dolores Angleton	American Red Cross	42	26,400	O/AID/REP
Pamela Hunte	Univ. of Conn.	42	18,900	O/AID/REP

2. Mission/Office Professional Staff Person-Days (estimate) 42

3. Borrower/Grantee Professional Staff Person-Days (estimate) 20

COSTS

A.I.D. EVALUATION SUMMARY PART II

J. SUMMARY OF EVALUATION FINDINGS, CONCLUSIONS AND RECOMMENDATIONS (Try not to exceed the 3 pages provided)
Address the following items:

- Purpose of activity(ies) evaluated
- Purpose of evaluation and Methodology used
- Findings and conclusions (relate to questions)
- Principal recommendations
- Lessons learned

Mission or Office: Office of A.I.D. Represent. Date this summary prepared: October 1987

Title and Date of Full Evaluation Report: PVO Co-Financing Project: Evaluation of Seven Health PVOs dated August 5, 1987

In June 1987, the Office of the AID Representative to Afghanistan (AID/REP) called for an evaluation of seven health PVOs. The Evaluation Team initiated work on June 21. This Evaluation of Health-Related Private Voluntary Organizations (PVOs) was completed on August 5, 1987. The specific PVOs included in the evaluation are:

(1) Mercy Corps International (MCI)
(2) International Medical Corps (ICM)
(3) Freedom Medicine (FM)
(4) German Afghanistan Committee (GAC)
(5) Medical Refresher Course for Afghans (MRCA)
(6) Medecins du Monde (MDM)
(7) Medical Training for Afghans (MTA)

These organizations are funded by the PVO Co-Financing Project (306-0201), which provides cross-border humanitarian assistance to not only in health but also in the areas of education, agriculture/rural development, and cash-for-food. All of the above PVOs are based in Pakistan and are involved in training cadres of young Afghan male health workers; the majority of them also support networks of health facilities such as clinics and hospitals inside Afghanistan itself.

The need for additional health care delivery services within Afghanistan is urgent. Since the Soviet invasion in 1979 and subsequent war, any fragile network of modern health-related services which did exist in rural Afghanistan has been broken. At present there is an acute lack of both health facilities and personnel throughout the country. In addition to a growing myriad of illnesses calling for primary health care, in recent years the war-related injuries to civilian men, women and children and to mujahiddin (resistance fighters) have also been widespread and devastating. Thus the need for first aid and surgical personnel is also acute. Since the war began, Afghans have fled across the Afghanistan/Pakistan border continually, and there are now an estimated three million refugees in Pakistan. In an effort to provide desperately needed health-related assistance inside Afghanistan and, to stem the flow of additional refugees into neighboring Pakistan, AID/REP supports the abovementioned PVOs in their cross-border humanitarian efforts.

The evaluation team, analyzed the following interrelated areas in order to assess PVO progress to date and to provide guidance to AID/REP for future cross-border health project development: (1) PVO project effectiviness in both Pakistan-based health worker training efforts and cross-border health service delivery inside Afghanistan, (2) degree of PVO compliance with monitoring and evaluation guidance provided by AID/REP and (3) PVO collaboration and coordination.

SUMMARY

This undertaking varies considerably from the usual health project evaluation in that it deals with distant PVO-sponsored activities taking place across the border in war-torn Afghanistan. Fieldwork has been carried out in Pakistan, and the team has not been able to observe first-hand the system of health service delivery being developed by the PVOs. Following an initial briefing/team planning session at AID/Washington in mid-June, 1987, the team met in Islamabad, Pakistan, for a detailed briefing by AID/REP staff. Considerable time was spent both in Quetta and Peshawar, with short trips taken to rural areas near the Afghan border (Thal and Sadda) where individual PVO training facilities are located.

Specific field methodology included (1) a detailed review of all seven PVO files project documents in the Office of AID/REP in Islamabad, (2) key informant interviewing of both expatriate and Afghan staff/students of each PVO, (3) participant observation at training facilities clinics and hospitals in order to evaluate teaching/translation techiniques and the practical work of students in training and (4) a review of curriculums seleections provided to the evaluation team by the PVOs themselves. Such field work furnishes the basis for the findings presented here.

PVO training courses (6-16 months in length) are producing qualified mid-level health personnel to work inside Afghanistan. Curriculum content varies and concise translation into Farsi and Pushto is often difficult. There is a high turnover in expatriate technical training staff. In spite of these constraints, staff and students are generally enthused and most graduates return to work in Afghanistan. Inside Afghanistan the PVOs reviewed here have succeeded in establishing separate networks of health facilities hospitals, clinics and mobile units in a total of 89 locations which are largely in the eastern regions.

Most PVOs do receive some communication from their graduates inside Afghanistan. Monitoring and evaluation efforts are being made, but systems for data collection and analysis still need improvement.

Coordination and communications between PVOs is a key to improving project effectiveness in both Pakistan-based training activities and cross-border health care delivery within Afghanistan. In this regard, the CMC (Coordination of Medical Committees) has been established by the seven PVOs reviewed here along with other cross-border voluntary organizationsworking in the health sector. The evaluation team strongly endorses CMC's coordinative role and recommends that AID/REP provide additional funds for its further establishment as requested in its pending proposal. We also recommend that the PVOs work together in the context of CMC to accomplish the following: (a) define and develop specific levels/skills for the mid-level health worker (Medics) which clearly state what a graduate of a training course should be able to do, (b) develop uniform core curriculum for this category of health personnel; these must be detailed, in-depth compilations and not simply basic outlines and (c) standardize treatment protocols utilizing the standard drug list.

PVOs should continually strive to recruit expatriate technical staff for long-term tours of duty (6 months or more) to assure training/general project continuity. Salary supplementation should be considered to enhance these posts.

Training should be as practical as possible, with every effort being made to train for the Afghan field setting. This necessitates knowing what that setting is. Thus as these cross-border projects develop and become more complex both in Pakistan-based training activities and in-service delivery inside Afghanistan, efforts must be made within each organization to carefully coordinate the activities on both sides of the border. General staff meetings should be held at least monthly in order to foster coordination and provide updates in progress.

The CMC should work to develop a procedure for the forming of multi-organizational and multinational evaluation teams who are acceptable to all participating PVOs. The specific format of the evaluation should include input from all PVOs.

When organizations reviewed here have established stronger foundations in the areas of training, monitoring and evaluation, individual PVOs could expand their activities to enable more graduates to be produced in order to better supply the necessary personnel for free Afghanistan's growing system of health care delivery.

Another evaluation similar to this exercise should be funded in 18-24 months. This time period should allow CMC to evolve into a viable coordinating body, and provide critical data in the future to determine how PVOs have contributed to overall health strategy for Afghanistan. By that time PVOs would also have further evolved and data found to be lacking at this point may be available. Valuable comparisons with this evaluation could then be made.

PVOs have a special role to play in health care delivery for Afghnistan; the evaluation team has found them to be staffed by extremely dedicated individuals, highly committed to providing effective humanitarian assistance to the Afghan populace. They are succeeding under very difficult and politically convolute conditions in establishing viable training courses and setting up various types of health care delivery systems on a limited scale. Their efforts should be encouraged by AID/REP and funding continued. The diverse multinational constituencies of PVOs provides a unique broad base of support in both funding and human resource expertise not available in single source donors/providers. We sincerely hope that this evaluation will furnish basic guidelines as to how PVOs can improve their programs to provide more effective cross-border health-related assistance to Afghans.

ATTACHMENTS

K. ATTACHMENTS (List attachments submitted with this Evaluation Summary; always attach copy of full evaluation report, even if one was submitted earlier)

PVO Co-Financing Project: Evaluation of 7 health PVOs.

"Evaluation of AID/REP-Assisted Private Voluntary Organizations (PVOs) Providing Health-Related Assistance to War-Affected Afghans", dated 8/5/87.

MISSION COMMENTS ON FULL REPORT

L. COMMENTS BY MISSION, AID/W OFFICE AND BORROWER/GRANTEE

O/AID/REP is very pleased with the through evaluation prepared by an excellent team. The team had an appropriate mix of professional and cultural skills, took the time necessary to thoroughly understand the milieu, and produced a professional report which was responsive to the scope of work and the needs of this office.

The team's report has been shared with the PVOs. We are strongly supporting an umbrella organization, the Coordination of Medical Committees (which this office helped to start) which is best situated to follow up on the team's technical recommendations.

PD-ABM-526-A

[redacted]

EVALUATION OF AID/REP-ASSISTED PRIVATE VOLUNTARY ORGANIZATIONS (PVOs) PROVIDING HEALTH-RELATED ASSISTANCE TO WAR-AFFECTED AFGHANS

PVO Co-Financing Project
(306-0201)

Afghanistan PVO Support Project
(398-0290)

by

Pamela A. Hunte, Professor of Anthropology
University of Connecticut
Storrs, CT

Dolores L. Angleton, Health Education Specialist
Devres, Inc.
Washington, D. C.

Sharon Benoliel, Program Analyst
Evaluation Office
Asia and Near East Bureau
Agency for International Development
Washington, D. C.

Submitted to the Office of the A.I.D. Representative
for Afghanistan Affairs
August 5,1987

[redacted]

DECLASSIFY: 8/5/92 LOU DECONTROL AFTER 8/5/92

[redacted]

TABLE OF CONTENTS

	Page
BASIC PROJECT IDENTIFICATION DATA SHEET	iv
LIST OF PVO GRANTS	v
EXECUTIVE SUMMARY	vi
I. INTRODUCTION	1
A. THE PVO CO-FINANCING PROJECT	1
B. THE SETTING	2
1. AFGHANISTAN: HEALTH STATUS AND NEEDS	2
2. PAKISTAN: THE SITUATION IN PESHAWAR AND QUETTA	4
C. PURPOSE AND METHODOLOGY OF EVALUATION	5
1. EVALUATION OF PVO ACTIVITIES IN PAKISTAN AND AFGHANISTAN	5
2. TEAM COMPOSITION	5
3. METHODOLOGY	6
D. BRIEF DESCRIPTION OF PVO PROGRAM	7
II. SYNTHESIS	11
A. PVO ORGANIZATIONAL STRUCTURE AND FUNCTION: GENERAL RECOMMENDATIONS	11
B. CURRICULUM AND TRAINING: GENERAL RECOMMENDATIONS	11
C. MONITORING AND EVALUATION: GENERAL RECOMMENDATIONS	11
D. COORDINATION AND COMMUNICATION BETWEEN PVOS AND WITH OTHER ORGANIZATIONS	12
E. THE ROLE OF AID/REP: GENERAL RECOMMENDATIONS	15
F. CONCLUSIONS	17
G. SUMMARY OF INDIVIDUAL PVO RECOMMENDATIONS	18
H. THE ALLIANCE	27
III. INDIVIDUAL PVO PROJECT SUMMARIES	30
A. MERCY CORPS INTERNATIONAL (MCI)	30
1. INTRODUCTION TO MCI	30
2. EDUCATIONAL COMPONENT	36
3. MONITORING AND EVALUATION COMPONENT	43
B. INTERNATIONAL MEDICAL CORPS (IMC)	56
1. INTRODUCTION TO IMC	56
2. EDUCATIONAL COMPONENT	59
3. MONITORING AND EVALUATION COMPONENT	65

Page

C. FREEDOM MEDICINE (FM) 74

1. INTRODUCTION TO FM 74
2. EDUCATIONAL COMPONENT 77
3. MONITORING AND EVALUATION COMPONENT 82

D. GERMAN AFGHANISTAN COMMITTEE (GAC) 90

1. INTRODUCTION TO GAC 90
2. EDUCATIONAL COMPONENT 93
3. MONITORING AND EVALUATION COMPONENT 97

E. MEDICAL REFRESHER COURSE FOR AFGHANS (MRCA) 105

1. INTRODUCTION TO MRCA 105
2. EDUCATIONAL COMPONENT 107
3. MONITORING AND EVALUATION COMPONENT 111

F. MEDECINS DU MONDE (MDM) 115

1. INTRODUCTION TO MDM 115
2. EDUCATIONAL COMPONENT 118
3. MONITORING AND EVALUATION COMPONENT 123

G. MEDICAL TRAINING FOR AFGHANS (MTA) 129

1. INTRODUCTION TO MTA 129
2. EDUCATIONAL COMPONENT 131
3. MONITORING AND EVALUATION COMPONENT 135

MAPS

MAP A: LOCATIONS OF HEALTH FACILITIES AND TRAINING COURSE GRADUATES IN AFGHANISTAN OF ALL PVOs REVIEWED (JULY 1987) 28
MAP B: HEALTH FACILITIES OF MERCY CORPS INTERNATIONAL (MCI) IN AFGHANISTAN (JULY 1987) 49
MAP C: HEALTH FACILITIES OF INTERNATIONAL MEDICAL CORPS (IMC) IN AFGHANISTAN (JULY 1987) 68
MAP D: APPROXIMATE LOCATIONS OF FREEDOM MEDICINE (FM) TRAINING COURSE GRADUATES IN AFGHANISTAN (JULY 1987) 86
MAP E: HEALTH FACILITIES OF GERMAN AFGHANISTAN COMMITTEE (GAC) IN AFGHANISTAN (JULY 1987) 101
MAP F: HEALTH FACILITIES OF MEDECINS DU MONDE (MDM) IN AFGHANISTAN (JULY 1987) 125
MAP G: APPROXIMATE LOCATIONS OF MEDICAL TRAINING FOR AFGHANS (MTA) TRAINING COURSE GRADUATES IN AFGHANISTAN (JULY 1987) 137

TABLES

		Page
1 -	Selected Characteristics of Cross-Border Health PVOs	29
2 - MCI -	Mercy Corps International Health Facilities in Afghanistan	50
3 - MCI -	Organization Diagram of Project	51
4 - MCI -	Admission and Retention Criteria	52
5 - MCI -	Medical Aid/First-Aid Course Structure, Certification and Assignment Specifics	53
6 - MCI -	Proposed Staffing Patterns - Afghanistan Facilities	55
7 - MCI -	Afghanistan Facilities (By Type)	55
8 - MCI -	Salary Structure Afghanistan Facilities	55
9 - IMC -	International Medical Corps Health Facilities in Afghanistan	69
10 - IMC -	Admission and Retention Criteria	70
11 - IMC -	Medic Course Structure, Certification and Assignment Specifics	71
12 - FM -	Freedom Medicine Graduated Students Now in Afghanistan	87
13 - FM -	Admission and Retention Criteria	88
14 - FM -	Medics Course Structure, Certification and Assignment Specifics	89
15 - GAC -	German Afghanistan Committee Health Facilities in Afghanistan	102
16 - GAC -	Admission and Retention Criteria	103
17 - GAC -	Dispenser Course Structure, Certification and Assignment Specifics	104
18 - MRCA -	Medical Refresher Course for Afghans Admission Retention Criteria	113
19 - MRCA -	Assistants Course Structure, Certification and Assignment Specifics	114
20 - MDM -	Medecins du Monde Health Facilities in Afghanistan	126
21 - MDM -	Admission and Retention Criteria	127
22 - MDM -	Proposed SUD/MDM-AVICEN Training Program	128
23 - MTA -	Medical Training for Afghans Graduates Students Now in Afghanistan	138
24 - MTA -	Admission and Retention Criteria	139
25 - MTA -	Assistant Doctors Course Structure, Certification and Assignment Specifics	140

APPENDICES

A - STATEMENT/SCOPE OF WORK	141
B - LIST OF INDIVIDUALS CONTACTED	145
C - GLOSSARY	148
D - ACRONYMS	149
E - THE ALLIANCE	150
F - AMI EVALUATION FORMAT	151

BASIC PROJECT IDENTIFICATION DATA

1. Country: Afghanistan

2. Project Title — 3. Project Number

Project Title	Project Number
Afghanistan PVO Support (451)	398-0290
PVO Co-Financing	306-0201

4. Project Dates:

Afghanistan PVO Support
a. First PVO Grant: July 15, 1985
b. Final Obligation: FY 1986

PVO Co-Financing
a. First PVO Grant: April 3, 1986
b. Final Obligation: FY 1991
c. Project Asst. Completion Date: March 17, 1992

5. Project Funding: (Health PVO components only)

a. A.I.D. Bilateral Funding:	(all grant)
Afghanistan PVO Support	$2,257,250
PVO Co-Financing: thru FY 87	$8,096,910
FY 88-FY 91	$4 - 5 million per year
b. Other Major Donors:	N/A (substantial to some PVOs)
c. Host Country Counterpart Funds:	N/A

6. Mode of Implementation: PVO Grants (list attached)

7. Project Design: ANE/PD, O/AID/REP

8. Responsible Mission Officials:
a. A.I.D. Representative: Larry Crandall
b. Project Officer: Carole Scherrer-Palma

9. Previous Evaluation: None

10. Cost of Present Evaluation:

	Person Days	Dollar Costs
a. Direct Hire:		
(1) AID/W TDY:	21	
(2) USAID staff:	20	
b. Contract	84	42,904
c. Other	Vehicular Support	

PVO GRANTS

PVO GRANTEE (GRANT NO.)	AMOUNT OF GRANT/AMENDMENT	DATE OF GRANT
1. 298-0290 Afghanistan PVO Support		
Americares/Medical Training for Afghans (5131)	126,000	09/15/86
Americares/Medical Refresher Courses for Afghans (5131)	174,000	09/15/87
International Medical Corps (5133)	675,360	10/11/85
Freedom Medicine (5145)	520,182	10/15/86
Americares/Medecins du Monde (6015)	311,708	11/01/86
German Afghanistan Committee (6037) Health Stations	450,000	04/25/86
Total Project	2,257,250	
2. 306-0201 PVO Co-Financing		
A. FY 1986	2,918,100	
International Medical Corps (5133)	1,170,000	04/30/86
Freedom Medicine (5145)	923,100	05/14/86
Mercy Corps International (6005)	600,000	09/23/86
Americares/Solidarite Afghanistan (5131)	125,000	08/05/86
German Afghanistan Committee (6008) Medic field manuals	100,000	08/03/86
B. FY 1987	5,178,810	
Americares/Med Refresher Training (7197)	50,600	08/00/87
Americares/Medecins du Monde (7195)	365,000	03/24/87
German Afghanistan Committee (7196) Health Stations	550,000	03/24/87
International Medical Corps (7200)	1,512,000	(expected)
Mercy Corps International (6005)	1,288,210	06/10/87
German Afghanistan Committee (6008) Medic Field Manuals	61,000	04/15/87
Americares/Med Training for Afghans	165,000	(expected)
Freedom Medicine	1,067,000	(expected)
International Rescue Committee/ Coordination of Medical Committees	120,000	(expected)
Total Project	8,096,910	
TOTAL PVO GRANTS	10,354,160	

EXECUTIVE SUMMARY

In June 1987, the Office of the AID Representative to Afghanistan (AID/REP) called for an evaluation of seven PVOs. The Evaluation Team initiated work on June 21. This Evaluation of Health-Related Private Voluntary Organizations (PVOs) involved in assistance to war-affected Afghans was completed on August 5, 1987. The specific PVOs included in the evaluation are:

(1) Mercy Corps International (MCI), USA
(2) International Medical Corps (IMC), USA
(3) Freedom Medicine (FM), USA
(4) German Afghanistan Committee (GAC), Germany
(5) Medical Refresher Course for Afghans (MRCA), France
(6) Medecins du Monde (MDM), France
(7) Medical Training for Afghans (MTA), Belgium/France

All of the above PVOs are based in Pakistan and are involved in training cadres of young Afghan male health workers: the majority of them also support networks of health facilities such as clinics and hospitals inside Afghanistan itself. These organizations are funded by the PVO Co-Financing Project (306-0201), which provides cross-border humanitarian assistance not only in health but also in the areas of education, agriculture/rural development and cash-for-food: $21.4 million of the $55 million committed to the cross-border program from its inception through FY 1987 has been devoted to the health sector. Assistance to the health-related PVOs covered by this evaluation amounted to $10.4 million out of $22.7 million devoted to PVO grants. (Another $2.4 million of this amount was devoted to health-related activities not within the scope of this evaluation.)

The need for additional health care delivery services within Afghanistan is urgent. Since the Soviet invasion in 1979 and subsequent war, any fragile network of modern health-related services which did exist in rural Afghanistan has been broken and, at present, there is an acute lack of both health facilities and personnel throughout the country. In addition to a growing myriad of illnesses calling for primary health care, in recent years war-related injuries to civilian men, women and children and mujahiddin (resistance fighters) have also been widespread and devastating. Thus the need for first-aid and surgical personnel is also acute. Since the war began, Afghans have fled across the Afghanistan/Pakistan border continually and there are now an estimated three million refugees in Pakistan. In an effort to provide desperately needed health-related assistance inside Afghanistan and, to stem the flow of additional refugees into neighboring Pakistan, AID/REP supports the abovementioned PVOs in their cross-border humanitarian efforts.

The evaluation team analyzed the following interrelated areas in order to assess PVO progress to date and to provide guidance to AID/REP for future cross-border health project development:

(1) PVO project effectiveness in both Pakistan-based health worker training efforts and cross-border health service delivery inside Afghanistan,

(2) degree of PVO compliance with monitoring and evaluation guidance provided by AID/REP,

(3) PVO collaboration and coordination.

This undertaking varies considerably from the usual health project evaluation in that it deals with distant PVO-sponsored activities taking place across the border in war-torn Afghanistan. Fieldwork has been carried out in Pakistan and the team has not been able to observe first-hand the system of health service delivery being developed by the PVOs. Following an initial briefing/team planning session at AID/Washington in mid-June 1987, the team met in Islamabad, Pakistan, for a detailed briefing by AID/REP staff. Considerable time was spent both in Quetta and Peshawar, with short trips taken to rural areas near the Afghan border (Thal and Sadda) where individual PVO training facilities are located.

Specific field methodology included:

(1) a detailed review of all seven PVOs' files/project documents in the Office of AID/REP in Islamabad,

(2) key informant interviewing of both expatriate and Afghan staff/students of each PVO,

(3) participant observation at training facilities, clinics and hospitals in order to evaluate teaching/translation techniques and the practical work of students in training, and

(4) a review of curriculum provided to the evaluation team by the PVOs themselves. Such field work furnishes the basis for the findings presented here.

PVO training courses (ranging from 6 to 16 months in length) are producing qualified mid-level health personnel to work inside Afghanistan. Curriculum content varies and concise translation into Farsi and Pushto is often difficult and there is a high turnover in expatriate technical training staff. In spite of these constraints, staff and students are generally enthused and most graduates return to work in Afghanistan. Inside Afghanistan the PVOs reviewed here have succeeded in establishing separate networks of health facilities, hospitals, clinics and mobile units in a total of 89 locations which are largely in the eastern regions.

Most PVOs do receive some communication from their graduates inside Afghanistan. Monitoring and evaluation efforts are being made, but systems for data collection and analysis still need improvement.

Coordination and communications between PVOs is a key to improving project effectiveness in both Pakistan-based training activities and cross-border health care delivery within Afghanistan. In this regard, the CMC (Coordination of Medical Committees) has been established by the seven PVOs reviewed here along with other cross-border voluntary organizations.

The evaluation team strongly endorses CMC's coordinating role and recommends that AID/REP provide funds for its further establishment as requested in its pending proposal. We also recommend that the PVOs work together in the context of CMC to accomplish the following: (a) define specific levels/skills for the mid-level health worker which clearly state what a graduate of a training course should be able to do, (b) develop uniform curriculum for this category of health personnel; these must be detailed, in-depth compilations and not simply basic outlines and (c) standardize treatment protocols utilizing the standard drug list.

PVOs should continually strive to recruit expatriate technical staff for long-term tours of duty (six months or more) to assure training/general project continuity. Salary supplementation should be considered to enhance these posts.

Training should be as practical as possible, with every effort being made to train for the Afghan field setting. This necessitates knowing what that setting is. Thus as these cross-border projects develop and become more complex both in Pakistan-based training activities and service delivery inside Afghanistan, efforts must be made within each organization to carefully coordinate the activities on both sides of the border. General staff meetings should be held at least monthly in order to foster coordination and provide updates in progress.

CMC should work to develop a procedure for the forming of multi-organizational and multi-national evaluation teams who are acceptable to all participating PVOs. The specific format of the evaluation should include input from all PVOs.

When organizations reviewed here have established stronger foundations in the areas of training, monitoring and evaluation, etc., individual PVOs could expand their training activities to enable more graduates to be produced in order to better supply the necessary personnel for free Afghanistan's growing system of health care delivery.

Another evaluation similar to this exercise should be funded in 18 to 24 months. This time period should allow CMC to evolve into a viable coordinating body and provide critical data to determine how PVOs have contributed to an overall health strategy for Afghanistan. By that time, PVOs would also have further evolved and data found to be lacking at this point may be available. Valuable comparisons with this evaluation could then be made.

PVOs have a special role to play in health care delivery for Afghanistan; the evaluation team has found them to be staffed by extremely dedicated individuals, highly committed to providing effective humanitarian assistance to the Afghan populace. They are succeeding under very difficult and politically convolute conditions in establishing viable training courses and setting up various types of health care delivery systems on a limited scale. Their efforts should be encouraged by AID/REP. Diverse multi-national constituencies of PVOs provide a unique broad base of support in both funding and human resources expertise not availabe from single source donors/providers. We sincerely hope that this evaluation will furnish basic guidelines as to how PVOs can improve their programs to provide more effective cross-border health-related assistance to Afghans.

EVALUATION OF AID/REP-ASSISTED PRIVATE VOLUNTARY ORGANIZATIONS PVOS PROVIDING HEALTH-RELATED CROSS-BORDER ASSISTANCE TO AFGHANISTAN

I. INTRODUCTION

A. The PVO Co-Financing Project

This evaluation is concerned with the activities of seven PVOs (Private Voluntary Organizations) presently based in Pakistan which are providing health-related cross-border assistance to Afghanistan. All of these organizations are being provided funds by the Office of the AID Representative for Afghanistan Affairs (AID/REP) through its PVO Co-Financing Project (306-0201). Other sectors included in the PVO Co-Financing Project are education, agriculture/rural development and cash-for-food.

Health-related assistance comprises a major portion of cross-border humanitarian undertakings, with some $21.4 million of the total $55.0 million allotted through FY 1987. A large portion of the health budget ($8.5 million) is allotted to the Health Sector Support Project (306-0203) under which Management Sciences for Health (MSH), a relatively recent AID/REP-sponsored organization, is working directly with the Seven-Party Alliance of the Afghan resistance and its Health Committee to develop a large-scale general framework for health service delivery inside Afghanistan. The health PVOs with which this report is concerned received $10.4 million. The other $2.4 million was devoted to health-related activities not within the scope of this evaluation.

A number of PVOs, both European and American, have been active in cross-border health work in the years since the Soviets invaded Afghanistan in 1979. US Government funding assistance began in 1985, with AID grants made to PVOs from Washington. An AID Office to administer assistance to cross-border activities was opened in Pakistan in the fall of 1985. Since then the number of PVOs receiving support increased.

The seven voluntary organizations examined here include the following[1]:

1. Mercy Corps International (MCI)
2. International Medical Corps (IMC)
3. Freedom Medicine (FM)
4. German Afghanistan Committee (GAC)
5. Medical Refresher Course for Afghans (MRCA)
6. Medecins du Monde (MDM)
7. Medical Training for Afghans (MTA)

All of these groups are involved in training cadres of young Afghan male health workers, while the majority of them also support networks of health facilities such as clinics and hospitals inside Afghanistan itself.

There are, however, also numerous differences between these PVOs in type, length and level of training, staffing, system of service delivery in Afghanistan, relations with Afghans and other important factors. These will be presented in detail in Section III of this report. As a brief introduction to this complex array of organizations, Table 1 on page 29 contains some summary information about these PVOs.

B. The Setting

1. Afghanistan: Health Status and Needs

The need for additional health care delivery services within Afghanistan (Map A, Page 28) is urgent. Any fragile network of modern health-related services which did exist in rural Afghanistan before the war has been broken in recent years and, at present, there is an acute lack of both health facilities and personnel throughout the country[2].

Even prior to the present conflict in Afghanistan, the health status of the populace left much to be desired, with extremely high morbidity and mortality rates. In recent years, the general health situation in Afghanistan has worsened due to a number of war-related disruptions. The sudden migration of whole villages of internal refugees within Afghanistan has caused overcrowding in some areas and has increased the likelihood of communicable diseases. Water systems have also been destroyed. Food supplies have decreased and are often prohibitive in costs. Transportation between rural and urban areas has drastically

1 The order of PVO reference utilized here and also throughout this report, reflects the schedule in which our research was undertaken.

2 Reference to Afghanistan in this report pertains primarily to the rural areas now under the control of the mujahiddin (resistance).

decreased, inhibiting contact with any remaining hospitals. Any DRA-sponsored attempt at health care delivery linked with indoctrination messages at the local level have long ago been violently rejected by the mujahiddin.

Although data concerning incidence and/or prevalence is lacking, the following general health problems are related as being very common inside Afghanistan today: tuberculosis, malaria, dysentery/diarrhoea, anemia, measles, chicken pox, whooping cough and upper respiratory illnesses. It is also reported that the nutritional status of communities in Afghanistan has declined, with food shortages existing in many areas. In addition to the bombing of irrigation systems, many fields have been abandoned by those farmers fleeing to Pakistan with their families while others have joined the mujahiddin (resistance). Traditional trade networks have been shattered and the cost of foodstuffs has skyrocketed. At present, however, starvation is not reported to be common; the staples of bread and dairy production seem readily available, but such nutritious foods as meat, eggs and vegetables are often in short supply. Thus undernutrition appears to be increasing which, correspondingly, increases the possibility of epidemics.

In addition to this growing myriad of illnesses, all of which also existed prior to the present crisis and which could largely be alleviated with effective primary health care activities, in recent years war-related injuries to civilian men, women and children and to mujahiddin (resistance fighters) have also been widespread and devastating. It is estimated that more than one million Afghans have been killed to date and, with thousands of casualties occurring each year, the need for first-aid and surgical personnel is also acute.

For treatment of the war-wounded, the International Committee of the Red Cross (ICRC) and other organizations have established surgical hospitals in Peshawar and Quetta (Map A, Page 28). It is usually only individuals with limb injuries who survive the long and arduous trip to the border and finally reach these facilities alive, however.

Skilled modern medical personnel working within Afghanistan are very few, with less than 100 doctors (both Afghan and expatriate) estimated to be active. There are, however, a number of Afghan medics with various degrees of training presently functioning throughout the whole region now under control of the mujahiddin; they are male health workers. As important as they may be for effective health care delivery to the populace, there are few--if any--modern Afghan female health practitioners and only a handful of female expatriate health practitioners working in mujahiddin-controlled areas of Afghanistan today. This is an extremely difficult setting for females to work, not as much because of the harsh environment as because of strong fundamentalist reaction to the Kabul regime's earlier attempts at radical reforms involving village women and, correspondingly, to activities pertaining to women today. Due to conservative sociocultural tenets,

many Afghan women are unable to see a male health practitioner for treatment; this does vary between ethnic groups, according to the female's age, however. In recent years in spite of the increasing aura of conservatism, it appears that there has been some general relaxation of this restriction--for example, in the case of the female war-wounded and also for some minor ailments. For gynecological problems, however, which are prevalent among the populace, male practitioners are seldom sought out for treatment.

Stationary clinics and some hospitals are in existence too, with some units sponsored by the various major Afghan political parties. See Appendix E for a listing of the major Afghan political parties which are based in Peshawar and which comprise the Seven-Party Alliance, and others by local commanders or by expatriate PVOs such as those reviewed here.

The present situation inside Afghanistan is extremely fluid, with only the slightest hint of an effective medical infrastructure being established. This complex process comprises the subject of this report.

2. Pakistan: The Situation in Peshawar and Quetta

In the years following the Soviet invasion in 1979, Afghans have fled across the Afghanistan/Pakistan border continually, and it is estimated more than three million refugees are in Pakistan--living primarily in the northern provinces of NWFP and Baluchistan (Map A, Page 28). The international response to this crisis has been great and, today, there are more than 70 humanitarian organizations (both government and private) working in Pakistan to assist the refugee population in the areas of health, education, income-generation, etc. In addition to a large United Nations effort, they are primarily from European nations, America and the Islamic world. The majority of their field offices are located in Peshawar, NWFP, with a small but growing number also based in Quetta (Map A, Page 28).

It is also in this context that the seven PVOs providing special cross-border health assistance which are reviewed here function. The field offices of IMC, FM, GAC, MRCA, MDM and MTA are all located in Peshawar, with only MCI working out of Quetta. These seven organizations are not the only ones working cross-border in the area of health; other expatriate groups include MSF (Medecins Sans Frontieres), NCA (Norwegian Committee for Afghanistan), a number of Saudi and Kuwaiti groups, etc. The Government of Pakistan has issued NOC (Non-Objection Certificates) to these cross-border PVOs, and although not overtly supportive of their activities (as is the case with refugee assistance), grants them the necessary permission.

All PVOs financed in part or whole by the US Government are prohibited from sending US citizens inside Afghanistan. This restriction, however, does not apply to other nationalities.

There is a constant flow of Afghans, both mujahiddin and civilians, to and from Afghanistan, and news of the war, political developments and other topics circulate fast throughout the Afghan and expatriate populace in Peshawar (and Quetta). It is a complex situation of intrigue in which information must be processed and filtered before being understood.

C. Purpose and Methodology of Evaluation

1. Evaluation of PVO Activities in Pakistan and Afghanistan

The purpose of this undertaking and major areas for exploration are outlined in the evaluation team's scope of work included in Appendix A. In brief, we have been concerned with the analysis of the following interrelated areas in order to provide guidance for future cross-border health project development:

a. PVO project effectiveness in both Pakistan-based health worker training efforts and cross-border health service delivery inside Afghanistan.

b. Degree of PVO compliance with monitoring and evaluation guidance provided by AID/REP.

c. PVO collaboration and coordination.

This undertaking varies considerably from the usual health project evaluation in that it deals with distant PVO-sponsored activities across the border within Afghanistan. The team has not been able to observe first-hand the systems of health service delivery being developed by the PVOs--e.g., how a medic functions in the field, clinic conditions, logistics of drug resupply, needs and impressions of the local populace, etc. This constraint has necessitated the compilation of second-hand data from a variety of sources in Peshawar and Quetta and their subsequent interpretation. As far as Pakistan-based training activities are concerned, however, we have been able to carry out extensive observation of the PVOs' various training facilities, and have attended classes and goat-labs, visited clinics and hospitals, and held discussions with both staff and students.

2. Team Composition

The evaluation team includes the following individuals, each with special areas of expertise which have complemented one another during this evaluation:

a. A medical anthropologist who has previously worked with health projects in both Afghanistan and Pakistan and who is fluent in Farsi (Afghan Persian).

b. A health education specialist who is an expert in disaster relief and who has also administered voluntary health projects.

c. A monitoring and evaluation expert who is based in the Asia/Near East Bureau in AID/Washington and provided the PVOs with monitoring and evaluation guidance on a previous visit in 1986.

Although there has been much overlap and exchange in research areas, the three team members have respectively focused on (a) organization structure and function/systems development, (b) curriculum and training activities and (c) monitoring and evaluation efforts. This breakdown is reflected in Section III of this report which contains individual project summaries for each of the seven PVOs that are organized according to this general tripartite scheme.

3. Methodology

Following an initial briefing/team planning session at AID/Washington in mid-June 1987, the team met in Islamabad, Pakistan, for detailed briefing by AID/REP staff. In summary, five days were spent in Quetta and three weeks in Peshawar with trips taken to rural areas near the border (Thal and Sadda) where individual PVO training facilities are located (Map A, Page 28).

Field methodology included the following activities;

a. A detailed review of all seven PVOs' files/project documents in the Office of the AID/REP in Islamabad.

b. Key informant interviewing: Structured problem-oriented conversations were conducted with both expatriate and Afghan staff of each PVO about the basic issues outlined above. Students in training were also interviewed, as were individuals from other relevant organizations. Both individual and group sessions were held. Appendix B contains a listing of specific persons contacted, along with their designation.

c. Participant observation: This was conducted at all Pakistan-based PVO training facilities, clinics and hospitals in order to evaluate teaching/translation techniques and the practical work of students.

d. Curriculum/Report Review: PVOs themselves provided the team with copies of their curriculums and any recent reports generated which were then reviewed in the field. Such fieldwork furnished the basis for the findings presented here.

At the outset it should be noted that in this report we have not generated a rating of the seven PVOs according to which one is best, second-best, etc. Each comprises a very different entity in and of itself, and the area of one's strengths may be the area of another's weaknesses. They reflect different goals and strategies, along with nationalities and they have been functioning for different periods of time. Thus, detailed across-the-board comparisons are impossible.

Section II contains a synthesis of all PVOs reviewed. It is here that generalizations concerning PVOs' areas of success and failure are discussed and recommendations on such major issues as organizational structure and function/systems development, curriculum and training, monitoring and evaluation and PVO collaboration and coordination are set forth.

Section III provides analyses and recommendations of each PVO. Departing from the usual evaluation format, specific recommendations have been made separately for our three major research areas: (1) organizational structure and function, (2) educational components and (3) monitoring and evaluation. For easy reference, all recommendations are listed on a summary sheet at the close of the the synthesis section.

D. Brief Description of PVO Programs

1. Mercy Corps International (MCI)

Active only since July 1986, Mercy Corps International (MCI) is, in comparison to other PVOs examined here, relatively new in its efforts to provide cross-border health-related assistance to Afghanistan. MCI's Pakistan office is based in the western city of Quetta rather than in Peshawar, and this further differentiates MCI from the other PVOs reviewed here (Map B, Page 49).

This organization, with its home office in Portland, Oregon, is primarily concerned with establishing and upgrading basic health care facilities in the southern and western regions of Afghanistan.[3] This is being accomplished by: (1) providing health care training for male Afghans in Quetta (three-month and six-month courses) and (2) establishing health care centers in southwestern Afghanistan for both the general population and the war-wounded. To date, MCI has graduated 38 "senior medics" and 88 first-aid workers; it has two hospitals, nine OPD clinics and eight mobile health units inside Afghanistan.

3 Mercy Corps International was established in 1979. Other international relief efforts of MCI take place in Sudan, Ethiopia, Honduras, Southeast Asia, etc.

2. International Medical Corps (IMC)

IMC was founded in 1984 by Dr. Robert Simon, Assistant Professor of Medicine at the UCLA Emergency Medical Center, Los Angeles, for the explicit purpose of providing medical assistance inside Afghanistan. Prior to AID/REP funding, this PVO had set up three small clinics in the southwestern section of the country with donated funds from the USA.

IMC presently trains Afghan "advanced surgical medics" in Pakistan who return to Afghanistan to work in IMC-supported health facilities. Emphasis is on providing assistance to far-flung regions of the country rather than just to the nearby border areas, whose populace it is assumed have better access to health care. Although initial concern was with training surgically skilled medics to deal with the war-wounded, recently a more general approach towards civilian health care has been implemented.

At present IMC carries out an eight-month training course in its Nasir Bagh Training Center which is located in a large refugee camp in the western suburbs of Peshawar. The first class began in January 1986 and to date a total of 128 students have completed various phases of training. Inside Afghanistan, IMC now supports 29 health facilities scattered throughout the country in which graduates of the training course work; these include 3 hospitals and 26 clinics (Map C, Page 68).

3. Freedom Medicine (FM)

Founded in 1983 and incorporated in 1985 to assist disaster-stricken areas, Freedom Medicine is a PVO whose activities focus only on Afghanistan. With its present home office in Honolulu, Hawaii, FM has been in operation for approximately one and one-half years. Its major goal is to train "quality health care medics" in a short period of time and to subsequently sustain and monitor their work inside Afghanistan.

To accomplish this, FM has established an administrative office in Peshawar and a training center/surgical hospital/OPD ("Fort Freedom") in Thal, a refugee-filled area of NWFP which is approximately 150 km southwest of Peshawar. In addition, FM has two paramedic stations near the border and a small clinic in Chitral.

Freedom Medicine's six-month medic training began in February 1986 and, to date, two classes have graduated. At present, approximately 19 students have returned to work inside Afghanistan. Most medics are from the central and northern regions of the country (Map D, Page 86).

4. German Afghanistan Committee (GAC)

In 1984, the Bonner Afghanistan Komitee (BAK) was founded in Bonn, Germany, by a small group of lawyers and doctors with the specific goal of providing humanitarian aid to the populace inside Afghanistan. Referred to more generally as the German-Afghanistan Committee (GAC), since January 1985 this organization has worked closely with a group of independent Afghans who had earlier been active in cross-border relief efforts. Primary objectives include the provision of health care to both the civilian and mujahiddin population and the fostering of medical personnel for the future of Afghanistan.

GAC has a home office in Bonn, one German and two Afghan offices in Peshawar, a medical training center for dispensers in Sadda, Tribal Areas (approximately 200 km southwest of Peshawar) and a small clinic and staging area in Miram Shah near the border. Training began in mid-1985, and, at present, there are 12 GAC-sponsored clinics located in central and eastern regions of Afghanistan (Map E, Page 101). Most of these "medical stations" are staffed by either an Afghan doctor or nurse and two or more GAC-trained "dispensers". In addition, European medical missions of German and/or Swiss physicians and nurses undertake periodic journeys to these health units to train, monitor and assist; seven such trips were undertaken in 1986, with a total of six planned for 1987.

AID/REP assists GAC with the support of its health facilities inside Afghanistan but not with its training activities in Sadda. GAC financing for training activities is obtained from the German Government and from private donations from Germany. The Swedish Committee also donates supplies of medicines.

5. Medical Refresher Course for Afghans (MRCA)

MRCA activities are centered in a 30-bed teaching/surgical hospital in Peshawar. This hospital was opened in April 1986, with the specific objective of providing refresher training to Afghan health workers. MRCA's work is thus complementary to that of other PVOs for it receives students from these organizations and provides them with tailor-made practical training in specialty areas: surgery, physical therapy, dentistry, x-ray and laboratory techniques. In contrast to the other PVOs reviewed here, MRCA does not have a system of clinics inside Afghanistan; its focus is rather upon training.

To date, approximately 46 Afghans have been trained at MRCA and, of these, 41 have returned to work in a variety of health facilities sponsored by other organizations inside Afghanistan.

6. Medecins Du Monde (MDM)

French doctors of MDM (Doctors for the World) first worked inside Afghanistan in 1980, and since 1981 expatriate teams have made regular trips of three to five months duration to Wardak Province. This French medical association was created in 1980 to aid populations throughout the world during disasters; it works internationally in 18 countries.

At present, MDM sends French medical teams to two general regions in Southeastern Afghanistan: (1) Wardak and Ghazni and (2) Kunar. In Wardak an underground hospital and two distant satellite dispensaries exist. In Kunar, MDM mobile teams are engaged in a vaccination campaign. Some training of local Afghans (12 nurses, 10 vaccinators) also takes place within Afghanistan (Map F, Page 125).

7. Medical Training for Afghans (MTA)

MTA activity is a direct response to the need for intensive training of Afghan medics as perceived by AMI, another PVO which has worked in health care delivery inside Afghanistan since 1980. AMI (with branches in both Paris, France and Liege, Belgium) and Solidarite Afghanistan/Belgium founded MTA with the explicit purpose of training in mind.

MTA training began in Fall 1985 at its 20-bed teaching hospital in Peshawar. At this facility students undertake a lengthy 16-month period of training, with both classroom work and daily practicum. In addition, MTA has a training clinic in Chitral in coordination with FM. Students also work in refugee camps at Hangu, southwest of Peshawar, and at a training site across the border in Afghanistan which is organized by AMI. There have been three small classes to date of approximately 37 students. Only one class of 11 has graduated, with six students who have returned to Afghanistan; the remaining five will go inside soon.

II. SYNTHESIS

It is evident from the following discussion that PVO training efforts can produce qualified mid-level health personnel to work inside Afghanistan. In the individual project summaries in Section III, the evaluation team has reviewed basic characteristics of each PVO and has provided specific recommendations based upon its analysis. In this section, however, we are concerned with more general considerations, and our recommendations will be directed at broad issues which pertain to future planning.

A. PVO Organizational Structure and Function

The PVOs reviewed here are in the process of change; each one, since its inception, has undergone modification due to individual field experiences, changes in Afghanistan, the Peshawar/Quetta settings and external developments such as the formation in 1985 of the Office of AID/REP. With the passage of time, staff size of each has increased and project implementation has become more complex. This evolution continues today.

General Recommendations

1) With respect to home office/field office relations, as much authority as possible should be assigned to the field office itself. Being familiar with the local environment, it is best able to make decisions.

2) Concerning organizational structure, for smooth functioning, PVOs should have both an administrative branch and a medical branch. The administrative branch can deal with the issues of personnel, general policy, budgets, relations with other PVOs, monitoring and evaluation, transportation and supplies, etc., while the medical branch can devote its energies to immediate problems of health training/service delivery.

3) As these cross-border projects develop and become more complex both in Pakistan-based training activities and service delivery inside Afghanistan, efforts must be made within the organization to carefully coordinate the activities on both sides of the border. General staff meetings should be held at least monthly in order to foster coordination and provide updates in progress.

B. Curriculum and Training

General Recommendations

1) Training should be as practical as possible with every effort being made to train for the Afghan field setting. This necessitates knowing what that setting is, which relates to our previous recommendation (A3).

2) PVOs should continually strive to recruit expatriate technical staff for long-term tours of duty (six months or more) to assure training/general project continuity. Salary supplementation should be considered to enhance these posts.

3) Training instructors should be able to teach effectively along with possessing clinical expertise; PVOs should build the capacity to educate within their staffs, along with recruiting individuals with this educative ability and experience.

4) The following recommendations pertain to the coordination of curriculum and training (see also Section D below concerning CMC). PVOs should work together to accomplish the following:

a. Define and develop skills list for the mid-level health worker which clearly states what a graduate of a training course should be able to do.

b. Develop a uniform core curriculum for this category of health worker; this curriculum must be detailed and in-depth compilations, not simply basic outline.

c. Standardize treatment protocols utilizing the standard drug list.

d. Utilize IRC translation services at its Health Education Resource Center in Peshawar to allow for uniform and relevant Farsi and Pushtu vocabulary and grammar. (NOTE: We also recommend that IRC establish a branch resource center in Quetta to provide similar much-needed services to PVOs working there.)

5) Concerning the important but often ignored question of health training for female Afghans, we recommend that this be given very cautious consideration. Settings within Afghanistan vary in degree of conservatism and generalizations are difficult. In a receptive context, female expatriates can informally instruct dais (traditional midwives) in basics of modern health care, along with receptive and carefully chosen women of the community. In some contexts, male expatriates and also Afghan PVO training course graduates can accomplish this too. This is a very sensitive issue that must not be forgotten.

C. Monitoring and Evaluation

General Recommendations

1) PVOs should develop an internal evaluation system to assess all aspects of their programs. Encouraging candid self-examination should be established within the organization.

2) A creative problem-solving approach should be taken by PVOs with respect to monitoring and evaluation rather than a mechanical input/output orientation. Data collected should serve a purpose in project planning/implementation and not simply serve as proof that goals have been achieved.

3) Data collected should be analyzed as much as possible in the field offices rather than being sent to the home offices. If field staff does not have the time to accomplish the task, individuals should be hired locally to do this; ideally, computers should be provided for this work.

4) A basic series of forms should be developed in conjunction with CMC for use by all PVO training course graduates in the field (Afghanistan). For example, clinic records, summary worksheets, drug utilization records, etc.

5) All PVOs should make every effort to coordinate with CMC to conduct medical assessments of clinics inside Afghanistan to evaluate effectiveness of training and service delivery.

D. Coordination and Communication Between PVOs and with Other Organizations

In the context of cross-border health-related assistance to Afghanistan, there are a number of participants, only some of which have been the subject of this evaluation. These include MSH (Management Sciences for Health), a Boston-based organization which administers an AID/REP-funded project for the development of an integrated system of health care delivery inside Afghanistan, the Seven-Party Alliance of major Afghan political parties with whom MSH is a counterpart and the Alliance Health Committee and the Coordination of Medical Committees (CMC).

The CMC is a forum of utmost importance for all of the PVOs reviewed here for both intra- and inter-PVO coordination. Informally established in Peshawar by a few cross-border health PVOs in late 1985, CMC today is a fast-developing functioning organization which has a number of crucial coordinating tasks to perform[4].

4 In addition, there is a Paris-based umbrella organization called the European Coordination for Humanitarian Aid Inside Afghanistan (CHEA) to which 19 European PVOs belong. Solidarite/Afghanistan (Belgium), Aide Medicale International (France), German Afghanistan Committee and Medecins du Monde are members. Only one US PVO, the Afghan Relief Committee, has been accepted by CHEA as an associate member. CHEA is considering the establishment of an office in Peshawar.

Most of the PVOs evaluated here are members (MCI and MDM plan to become full members next month). CMC has its own office, along with a staff composed of an Administrative Director and a Medical Director; there are weekly meetings held in Peshawar to which all member organizations send representatives.

General Recommendations

1) The evaluation team strongly endorses CMC's coordinating role and recommends that AID/REP provide funds for its further establishment in its pending proposal.

2) The CMC should appoint various subcommittees to accomplish different coordinating tasks (e.g., a curriculum subcommittee, a monitoring and evaluation subcommittee, a medical subcommittee, etc.). For example, some activities of the medical subcommittee could be: (a) to compile summaries of information concerning clinic data received from PVOs and to assist in the analysis of such and (b) to standardize medical terminology in Farsi and Pushtu for translation, etc. A subcommittee dealing with monitoring and evaluation could: (a) prepare acceptable lists of available doctors and other medical personnel (both expatriate and Afghan, excluding Americans) for evaluation missions inside Afghanistan and (b) plan and coordinate along with the medical subcommittee epidemiological and medical-sociocultural studies.

3) A Board of Trainee Evaluators should be created to examine graduates from all member PVO training activities in order to ascertain what levels and what posts they can best fill. Relevant salary scales should be determined according to level of training and not merely by length of training course.

4) Not all members of CMC are native English-speakers and efforts should be made in discussions to ensure that all feel comfortable enough linguistically to participate openly.

5) The CMC should work to develop a procedure for the forming of multi-organizational and multi-national evaluation teams who are acceptable to all participating PVOs. The specific format of the evaluation should include input from all PVOs.

6) PVOs do not clearly understand what MSH's activities are and MSH does not have an understanding of various PVO undertakings. There must be a forum for the regular exchange of this information. CMC should grant MSH observer status in its organization or hold additional meetings with MSH periodically.

7) The CMC (and PVOs in general) should become more oriented towards trusting and accepting activities conducted by Afghans themselves. Granted, in this setting there are many personal and political motivations involved, and information must be carefully processed. The

inclination is, however, to value expatriate training, data collection, monitoring and evaluation far above that conducted by Afghans. This orientation is elitist and naive.

E. The Role of AID/REP

The general environment of Afghanistan and Pakistan, to say the least, is one of volatile situations, complex and convoluted political and personal relationships and a myriad of "players". This environment complicates the ability of AID/REP to accomplish goals with any assurity of performance or specific time sequencing. Non-withstanding significant progress has been made. The AID/REP Special Projects Officer/Health has provided valuable guidance for the PVOs reviewed here, both individually and in their collective efforts to establish the CMC, and she has their confidence and respect.

Recommendations

1) The Project Officer should continue to serve as a catalyst for better communications between CMC and MSH in Peshawar by holding general meetings, initially to simply familiarize PVOs with MSH and vice versa, and only later moving to important planning and coordination issues for the future.

2) The CMC proposal submitted to AID/REP now under consideration should be funded and the organization should be strongly supported.

3) Quarterly reports should continue to be required from all PVOs funded. In addition to their value to the AID/REP, these are excellent exercises for PVOs to reflect upon and summarize their undertakings. Stress should be on the submission of timely reports containing organized and logically-presented data. Individual PVOs may need additional guidance on a one-to-one basis in this area.

4) MSH trains, through the Alliance, only BHWs (Basic Health Workers); PVOs train medics/mid-level health workers. These health personnel are complementary and should work together. Without upsetting the present PVO system of service delivery inside Afghanistan, AID/REP should foster coordination between these health workers as, corespondingly, they should foster coordination between PVOs, CMC and MSH. A small case study should be organized with the agreement of all concerned parties in which only three PVO-trained medics are appointed in three different MSH-Alliance clinics and work with teams of the MSH-affiliated BHWs in Afghanistan. Monitoring and evaluation of the units should be a joint PVO/CMC/MSH venture, with multi-organizational teams accomplishing the task. This case study would yield valuable information for future planning and provide a concrete setting about what to communicate.

5) Another evaluation similar to this exercise should be funded after a period of 18 months to 2 years. By that time, the PVOs and CMC would have further evolved and data found to be lacking at this point may be available. Valuable comparisons with this evaluation could then be made for future decisions regarding PVO contributions to an overall health strategy for Afghanistan.

6) When organizations reviewed here have established stronger foundations in the areas of administration, training, monitoring and evaluation, individual PVOs could expand their activities to enable more graduates to be produced in order to better supply the necessary personnel for free Afghanistan's growing system of health care delivery.

7) Concerning the important but often ignored question of health training for female Afghans, we recommend that this be given very cautious consideration. Women's mobility is often restricted to the household or community, as is their contact with non-family members and strangers. Recent unrest due to the war has led to increased fear and suspicion and combined with the growth of conservative Islam, this has had repercussions on the role of women. Settings within Afghanistan vary in degree of conservatism, however, and generalizations are difficult.

There are two alternatives with respect to training location: in Pakistan (Peshawar or Quetta) or inside Afghanistan itself. Only two types of women could participate no matter where the training site: the older illiterate woman such as the dai (traditional midwife[5]; a popular health practitioner in Afghanistan for both mother and child health care delivery) or the young literate woman (similar to the PVO male students reviewed here). It would be very difficult to bring either type of female from Afghanistan--the first type could probably not come alone and would have to have an escort (a son, husband, etc.) or live with relatives. It is questionable how large a pool of young literate women exists in areas of Afghanistan controlled by mujahiddin, and they certainly could not come alone either.

Training in Afghanistan holds more promise but is also filled with constraints. First of all, the community's feelings about training for women must be explored in detail. In a receptive context, female expatriates (such as those very few who work periodically with GAC or MDM) can informally instruct dais (traditional midwives) in basics of modern health care, along with receptive and carefully-chosen other women of the community. In some contexts (such as in the north), male expatriates and also Afghan PVO-training course graduates can accomplish this too. This is a very sensitive issue, and caution must be taken to

5 In pre-war Afghanistan (mid-1970s), the Government along with MSH assistance had initiated a relatively successful dai training project for rural areas throughout the country.

avoid any conservative backlash against "foreign" influence. If any pilot project is initiated, it should be very small and not overly ambitious. The need is great, however, for trained female health workers for both mother and child health.

F. Conclusions

PVOs have a special role to play in health care delivery for Afghanistan; the evaluation team has found them to be staffed by an extremely dedicated array of individuals who are highly-committed to providing effective humanitarian assistance to the Afghan populace.

They are succeeding under very difficult and politically-convoluted conditions in establishing viable training courses and setting up various types of health care delivery systems on a limited scale. The diverse multi-national constituencies of these PVOs provide a unique broad base of support in both funding and human resource expertise not available from single source donors/providers.

Clearly, there are many areas for PVO project improvement and refinement, however. We sincerely hope that this evaluation will furnish basic guidelines as to how this can be achieved in order to provide more effective cross-border health-related assistance to Afghans.

The following section (Summary Recommendations) is an abridged version of those found in each PVO program. For more information on these recommendations, please refer to Section III - Individual Project Summaries.

G. Summary of Individual PVO Recommendations

Mercy Corps International (MCI)

Organization

1. Efforts must be made to recruit key expatriate technical staff who are willing to stay for six months to one year.

2. As the Al-Jehad Training Hospital begins to function, training activities and surgical patient care activities must be clearly defined and coordinated. Detailed job descriptions for all staff should be prepared.

3. The system of communications with health facilities inside must be perfected. The shula-i-clinic (clinic committees) are important in that local communities are involved, and their formation and function should be monitored.

4. As MCI activities develop in complexity both in Pakistan and Afghanistan, staff in Quetta should have more general strategy meetings in which information is shared and progress, problems and future plans of each subsection of the office are discussed.

5. MCI should send a representative to CMC meetings in Peshawar. In addition, the CMC Medical Director and Administrative Director should viisit MCI in Quetta in order to better understand this PVO's role.

Education

1. Reevaluate MCI education substructure to ensure adequate staff for the overall planning and development of the education program.

2. Reevaluate theoretical content level for appropriateness/ need. Identify essential information and skills required. Build curriculum base around essential knowledge and skills and integrate practice throughout course. Incorporate additional teaching methods and further enhance visual and practical teaching tools.

3. Obtain quality translations of all material and provide students with copies or composite reference manuals.

4. Reevaluate capacity and cost-benefit of training x-ray technicians.

5. Change the three-month first-aid course to a one-month pre-requisite to the six-month course. The one-month course should cover essential first-aid skills only.

6. Develop and implement specific skills list system to monitor each individual student's performance, completion and level of achievement.

7. Develop/strengthen strategies to recruit and develop additional Afghan professionals as instructors and translators.

8. Seek closer cooperation with other PVOs and CMC for resource sharing and coordination.

9. Improve student recruitment strategies to provide a larger selection pool.

10. Develop specific job descriptions for instructors/trainers to assist in advance recruitment and selection, particularly of expatriate staff.

11. Improve home office support of recruitment system and field supply needs.

Monitoring and Evaluation

1. Develop an overall written strategy for M&E.

2. In conjunction with CMC, conduct medical assessments of MCI clinics inside Afghanistan on an annual basis.

3. Review data collected annually to determine their utility for problem-solving and decision-making.

4. Following each quarterly report, the staff should meet to review findings and develop action plans addressing identified problem areas.

International Medical Corps (IMC)

Organization

1. Effort should be made to recruit expatriate technical staff for six months or one year.

2. A better relationship between home and field office should be developed and field staff should be given more decision-making power.

3. As much data analysis as possible should be done in the field.

Education

1. Identify, develop, implement and maintain a specific skills list to monitor individual student performance, completion and level of achievement.

2. Identify and develop/strenghten specific curriculum areas.

3. Complete and standardize curriculum content. Designate a curriculum committee to decide on future changes.

4. Complete/develop student materials with attention to design, format and reproduction quality for dual study and field reference use.

5. Further enhance teaching tools and methods.

6. Strengthen instructor selection and assignment system to include evaluation of teaching skills pre- and post-assignment.

7. Develop/strengthen strategies to recruit and develop additional Afghan professionals as future instructors to the maximum number possible.

8. Recruit and adhere to assignment of each education medical director for a minimum one course assignment duration.

9. Work directly with other PVOs to develop a unified core curriculum.

Monitoring and Evaluation

1. Develop an overall written plan for monitoring and evaluation.

2. Analyze and interpret data in IMC/Peshawar with input from Afghan staff.

3. In conjunction with CMC, conduct medical assessments of clinics inside Afghanistan on an annual basis.

4. Review data annually to determine utility for problem-solving and decision-making.

5. Following each quarterly report, the field staff should meet to review findings and develop a coordinated home office and field plan of action for addressing problem areas.

6. Quarterly reports should reflect objectives to have been achieved and progress to date with tabular data comparison. Analysis/interpretation of data should be included as well as detailed information on functioning of clinics inside.

H. The Alliance

(MAJOR AFGHAN POLITICAL PARTIES/LEADERS BASED IN PESHAWAR)

	Name	Name
1.	MAHAZ-I-MILLI ISLAMI (National Islamic Front)	SYED AHMAD GAILANI
2.	JABHA-NAJAT-I-MILLI AFGHANISTAN (National Liberation Front	SEBHATULLAH MUJADIDI
3.	HARAKAT-I-ISLAMIC	MAULAVI MOHAMMAD NABI MOHAMMEDI
4.	HEZBI-I-ISLAMI	MAWLAWI MOHAMMAD YONUS KHALIS
5.	HEZBI-I-ISLAMI	GULBUDDIN HIKMATYAR
6.	ETEHAD-Islami	PROF. RASOOL SAYYAF
7.	JAMIAT-I-Islami Afghanistan	PROF. BURHANUDDIN RABBANI

The popular party name is underlined here; in this report leaders names are used with reference to the parties.

Freedom Medicine (FM)

Organization

1. The general administration of FM must be improved and authority delegated to the new staff members.

2. Efforts should be made to recruit expatriate technical staff for the duration of each training course.

3. FM must obtain information about its assigned graduates and their activities inside Afghanistan.

Education

1. Establish and implement an expanded administrative table of organization with specific identified roles, responsibilities and authorities.

2. Finalize and implement curriculum as designed, including student reference material.

3. Establish a mechanism for future revision of curriculum based on analysis of need and program impact.

4. Develop cooperative arrangements to obtain needed inside evaluation information.

5. Identify, develop, implement and maintain a skills list system to monitor individual student performance, completion and level of achievement.

Monitoring and Evaluation

1. Develop an overall written strategy for monitoring and evaluation.

2. Develop a checklist to assess students' work in Afghanistan.

3. In conjunction with CMC, conduct medical assessments of the performance of its graduates inside Afghanistan on an annual basis.

4. On an annual basis, review all data collected to determine utility for problem-solving and decision-making.

5. FM should improve and submit timely substantive quarterly reports relating to specific objectives/targets to the specific degree of accomplishment, and problems and action plans.

German Afghanistan Committee (GAC)

Organization

1. Relations between home and field office must be improved. Field staff should be delegated authority to make decisions on day-to-day operations.

2. Data should be analyzed in the field before being sent to Germany.

Education

1. Support and supply the education program and facilities at a level consistent with quality education and service delivery.

2. Seek closer cooperation with other PVOs and CMC for education resource sharing.

3. Identify, develop and implement a specific skills list system to monitor each individual students' performance, completion and level of achievement.

4. Incorporate additional teaching methods such as planned practical/field exercises, group skill sessions and laboratory sessions to decrease lecture format and reinforce understanding.

Monitoring and Evaluation

1. Develop an integrated overall written strategy for monitoring and evaluation of the various components of total project.

2. Current data should be reviewed and needed additions/deletions identified.

3. Review data annually to determine utility for problem-solving and decision-making and change/discard as appropriate.

4. Submit physicians' reports along with quarterly reports detailing the objectives and results of each medical mission.

Medical Refresher Course for Afghans (MRCA)

Organization

1. The Director of MRCA should consider the employment of an Administrative Assistant (Afghan).

2. All efforts should be made to recruit expatriate staff for a longer period than three months to ensure project/training continuity.

Education

1. Develop and implement a specific skills list system to monitor each individual student's performance, completion and level of achievement.

2. Seek closer cooperation with other PVOs/organizations for assistance with performance feedback of graduates in the field.

3. Develop laboratory "specialty" capacity to offer course for laboratory personnel.

4. Consider development of an advanced surgical course to include additional procedures for selected participants over a longer period of time (future).

Monitoring and Evaluation

1. Develop system for obtaining relevant inside information regarding student performance and educational needs.

2. Develop and implement overall written strategy for assessment of instructors and students.

3. Institute periodic staff meetings for problem-solving and decision-making.

Medecins du Monde (MDM)

Organization

1. MDM should be encouraged to involve more Afghans in its expatriate system of health care delivery.

2. MDM should be encouraged to analyze its two-year supply of clinic records in detail.

3. MDM interest in evaluation should be encouraged and coordinated with similar desires of other PVOS.

Education

(Note: MDM's training program is not funded by the US Government. However, the following recommendations are offered for its consideration.)

1. Develop written basic education plan/structure for training of Afghan nurses, including:

*-- specific recruitment and selection criteria and mechanisms;

*-- specific basic curriculum content and subject matter for each area taught including identified skills and methods of instruction;

*-- student monitoring and evaluation system for education structure;

*-- appropriate systems to support program.

*-- implement and support education plan/structure with appropriate staff, material and supplies.

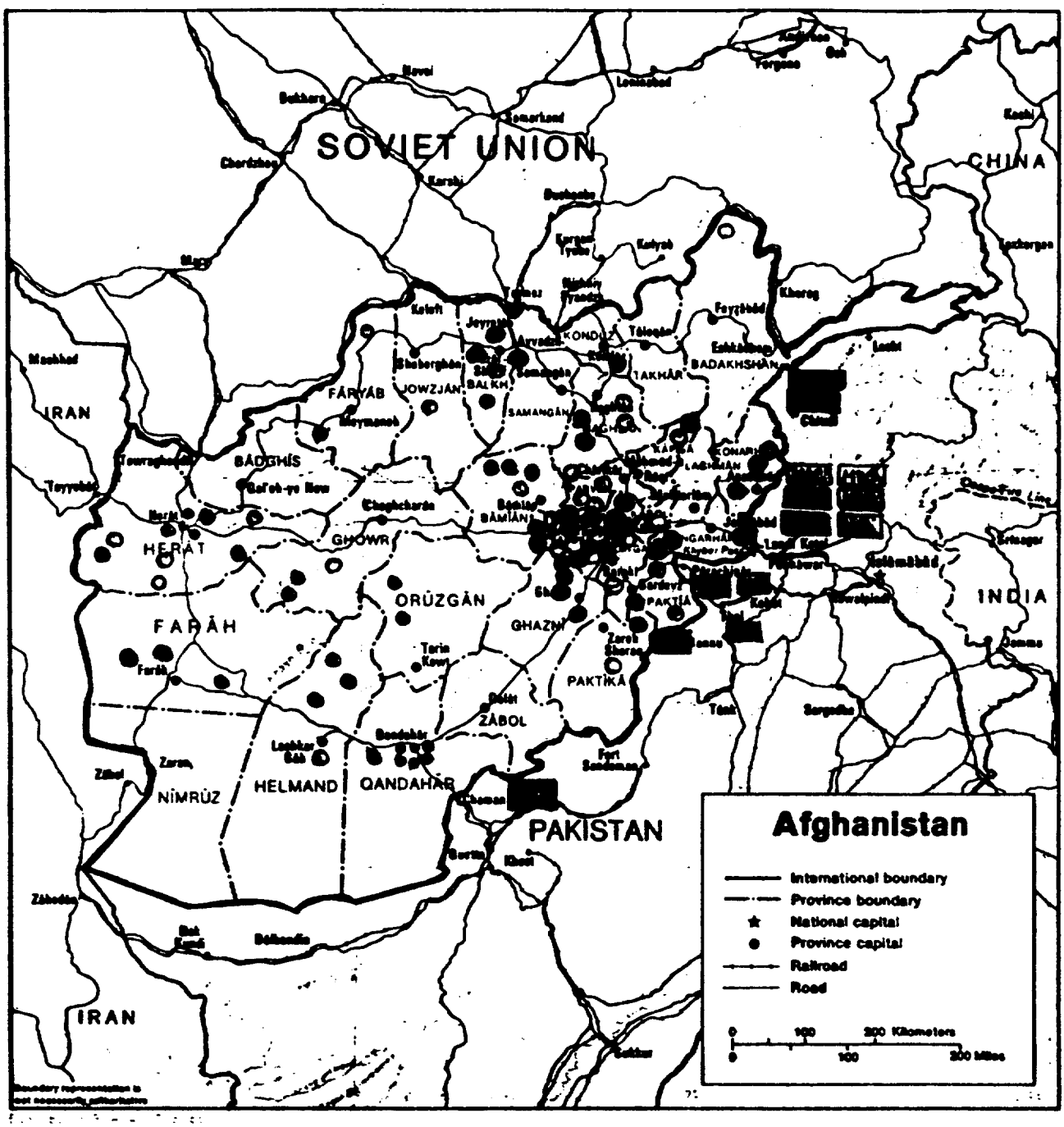
*-- seriously consider addition of education specialist to design and develop education program.

2. When SUD/MDM/AVICEN training program is funded and further developed, these recommendations apply to this education offering as well prior to program implementation.

Monitoring and Evaluation

Develop an overall written strategy for monitoring and evaluation. Quarterly reports should relate to objectives/targets and the specific degree of accomplishment. Data collected should have feedback loops to the field and be incorporated into a subsystem decision-making processes.

MAP A: LOCATIONS OF HEALTH FACILITIES AND TRAINING COURSE GRADUATES IN AFGHANISTAN OF ALL PVOs REVIEWED (July 1987)



- Mercy Corps International (MCI)
- International Medical Corps (IMC)
- Freedom Medicine (FM)
- German Afghanistan Committee (GAC)
- Medecins du Monde (MDM)
- Medical Training For Afghans (MTA)

Previous Pages Blank
Pgs 26-27

[redacted]

TABLE 1: SELECTED CHARACTERISTICS OF CROSS-BORDER HEALTH PVOs

PVO	Funding	Office	Focus of PVO Work	Type of Assistance P=Pakistan A=Afghanistan	Date PVO Began Work in Pakistan	PVO Pakistan Office Location	Service Facilities in Pakistan	Service Facilities in Afghanistan	Students Now in Trg	Students Graduated	Students Working Inside Now	# Provinces Working in Afghanistan
Mercy Corps International (MCI)	Thru FY86: $ 600,000 FY87: $1,288,210	Portland Oregon USA	International	Medic Trg (P) Basic Health Worker Trg (P) Teaching Hospital & OPD (P) Field Clinics (A)	July 1986	Quetta Baluchistan	1 OPD 1 Trg Surg Hosp	2 Hospital 9 Clinics 8 Mobile Teams	34	38	19	6
International Medical Corps IMC)	Thru FY86: $1,845,360 FY87: $1,512,000	Los Angeles California USA	Only Afghanistan	Medic Trg (P) Teaching OPD (P) Field Clinics (A)	Late 1984	Peshawar NWFP	1 OPD	3 Hospital 26 Clinics	32	58*	44	16
Freedom Medicine (FM)	Thru FY86: $1,443,282 FY87: $1,067,000	Honolulu Hawaii USA	Only Afghanistan	Medic Trg (P) Teaching Hospital/OPD (P)	Mid-1985	Peshawar NWFP	2 OPD 1 Trg Hosp	(Unk)	18	31	13	11
German Afghanistan Committee (GAC)	Thru FY86: $ 450,000 FY 87: $ 550,000	Bonn West Germany	Only Afghanistan	Dispenser Trg (P) Expatriate Medical Teams (A) Field Clinics (A)	Mid-1985	Peshawar NWFP	2 OPD	12 Clinics	8	42*	30	7
Medical Refresher Course for Afghans(MRCA)	Thru FY86: $ 174,000 FY87: $ 50,600	Paris France	Only Afghanistan	Refresher/Special Tech Trg for Medics (P)	1985	Peshawar NWFP	1 Tng Surg Hosp	(N/A)	43	46	41	(N/A)
Medecins du Monde (MDM)	Thru FY86: $ 311,708 FY87: $ 365,000	Paris France	International	Expatriate Medical Teams (A) Teaching Hosp/Nurses (A) Vaccination Projects (A)	1980	Peshawar NWFP		1 Hospital 2 Dispen-saries 1 Mobile	12		12	3
Medical Training for Afghans (MTA)	Thru FY86: $ 251,000 FY87: $ 165,000	Leige Belgium Solidarite Afghanistan	Only Afghanistan	Expatriate Medical Teams (A) Teaching Hospital (A)	1985	Peshawar NWFP	1 Tng Hosp 2 OPD	(Unk)	27	11	6	3
		Paris France AMI (Aide Medicale Internationa	International		1983							

* Phased Programs - not all students have completed all phases.

III. INDIVIDUAL PROJECT SUMMARIES

A. Mercy Corps International (MCI)

1. Introduction to MCI

a. Location, General Objectives

Active in Pakistan only since July 1986, Mercy Corps International (MCI) is, in comparison to other PVOs examined here, relatively new in its efforts to provide cross-border health-related assistance to Afghanistan. MCI's Pakistan office is based in the western city of Quetta rather than in Peshawar, and this further differentiates MCI from the other PVOs reviewed here (Map B, Page 49).

MCI with its home office in Portland, Oregon, is primarily concerned with establishing and upgrading basic health care facilities in the southern and western regions of Afghanistan[6]. This is being accomplished by: (1) providing health care training for male Afghans in Quetta (three-month and six-month courses) and (2) establishing health care centers in southwestern Afghanistan for both the general population and the war-wounded. To date, MCI has graduated 38 "senior medics" and 88 first-aid workers; it has 2 hospitals, 9 OPD clinics and 8 mobile health units inside Afghanistan (Map B, Page 49).

b. Organizational Structure and Function

(1) MCI Office in Pakistan

In its first year of existence, MCI has devoted much attention to the establishment of a well-organized and smoothly functioning field office and, to a large extent, this has been achieved. As illustrated in Table 3, the Country Director (an experienced individual who has previously worked with MCI in other LDCs) is assisted by individual staff members in general administration in addition to those involved in medical training and management. Personnel are dedicated and extremely hard-working.

At the time of our research the important posts of physician/trainer and nurse practitioner/administrator both remained unfilled and the Country Director himself was in the Philippines attempting to recruit these staff members. As discussed below, lack of such central team members has had repercussions in general project functioning.

6 Mercy Corps International was established in 1979--other international relief efforts of MCI take place in Sudan, Ethiopia, Honduras, Southeast Asia, etc.

A recent undertaking of MCI is the Al-Jehad Training Hospital, a newly established 30-bed surgical unit inaugurated during our field research in Quetta which, along with the previously existing Al-Jehad OPD Clinic, will serve as a training site for MCI students. As the new training hospital's undertakings grow, the need to fill empty staff posts will become more acute. In the hospital context, training activities and surgical/patient care activities must be clearly differentiated and coordinated. In addition, as more students complete training and return to Afghanistan, increased coordination in general between various sectors of MCI field staff--both those involved in Pakistan-based activities and those dealing directly with Afghanistan-based activities--is of utmost necessity. In short, MCI is young and has ambitious plans for future development; this can be achieved with continued attention towards administrative relations and general office coordination.

(2) Relations Between Home Office and the Field

In general, there appear to be very positive relations between the 15-member MCI home office in Portland, Oregon, and the field. Authority to make major day-to-day decisions rests with the field staff, with the home office providing any needed support. Communication includes telexes twice weekly and occasional phone calls; also during the past year three visits have been made to Quetta by home office staff, including the President of MCI himself. When the evaluation team was in Quetta, the Country Director was en route to the Home Office to attend a general MCI conference and deal with difficult recruitment problems.

(3) Coordination with Afghans in Pakistan and Afghanistan

(a) The Quetta Setting

There are some general characteristics of the Afghan populace found in Quetta, Baluchistan, which vary somewhat from that in Peshawar, NWFP, and which affect a Quetta-based PVO project such as MCI. In comparison to Peshawar, which has received the majority of educated urban refugees fleeing from the Afghan capital of Kabul who are now in Pakistan, Quetta's Afghan refugee population is largely of rural origin with only a limited pool of individuals who have obtained high school diplomas or who speak English. This makes it difficult for MCI to locate qualified Afghans to participate as either technical staff or as translators[7].

In addition, the type of student who comes to Quetta from southwestern Afghanistan to attend MCI's training courses is often from a rural setting and has not attained the level of education found among many of those trainees enrolled in similar Peshawar-based PVO projects.

7 Translation is necessary in either Pushtu and Farsi; most classroom work is conducted in Pushtu.

The Afghan political situation in Quetta is also different from that found in Peshawar where the Alliance and individual party headquarters are found. Due to sheer distance and other factors, communications between party members in Quetta and Peshawar is often poor, with those members in Baluchistan frequently feeling ignored. This has resulted in a willingness in Quetta for inter-party cooperation at times, one illustration of which is the MCI Board.

These factors make such project activity in Quetta a special challenge and call for resourceful and creative training efforts.

(b) Jamiat-Al-Ulama and MCI

The present senior Afghan staff of MCI have been involved in cross-border health-related undertakings since 1981--long before this PVO teamed up with them to furnish additional funding and administrative expertise in 1986. Indeed, these Afghans, who comprise an association called Jamiat-al-Ulama (Union of Intellectuals) established the framework for present MCI activity; they developed a training course, established Al-Jehad OPD Clinic, and initiated health facilities in southwestern Afghanistan. Since 1986 MCI has supported and strengthened these activities and, in coordination, Jamiat-Al-Ulama and MCI have fostered the newly established Al-Jehad Training Hospital.

(c) Afghan Parties, Commanders and MCI

One of the major achievements of MCI in Quetta has been the establishment in July 1986 of a Board of Directors which is composed of medical representatives from each of the seven major Afghan political parties (Appendix E). Four of these seven representatives are physicians, the expatriate Country Director is Chair and MCI senior Afghan staff are non-voting members. This Board schedules meetings approximately every three to four weeks to discuss policy matters--student admissions, training curriculum and location of clinics inside Afghanistan.

Initial permission in 1986 to form the Board was obtained by MCI from the spokesman for the Alliance at the time, Professor Rabbani. At present, some participation is obtained from all parties, with some reticence on the part of Etehad (Sayyaf). Thus, in spite of some general ambivalence on the part of Board members towards senior MCI Afghan staff and numerous delays in decision-making due to lack of consensus among participants, the MCI Board is a functioning unit of utmost significance in fostering cooperation among Afghans.

It should be noted that commanders inside Afghanistan of varying degrees of party loyalty nominate their local individuals for the MCI 6-month training program; the nominees' applications are then presented by party representatives at MCI Board meetings in Quetta.

(d) General Framework for Service Delivery in Afghanistan:

As outlined in Table 2 (page 50), MCI has 11 fixed health facilities (2 hospitals and 9 clinics) along with 8 mobile units functioning inside Afghanistan. Map B (page 49) illustrates the approximate locations of these facilities, all of which are in the southwestern portion of the country.

The general design presented here is new and, to date, MCI has not received much feedback from its health facilities inside Afghanistan. The first MCI-trained students only completed classes this spring and returned to Afghanistan in May 1987. The plan thus remains to be perfected.

The locations for MIC health facility sites were chosen with a number of considerations in mind:

1. need for medical services in the area,
2. degree of local political harmony, and
3. general security against outside attack in the area.

These sites were determined primarily by two senior Afghan MCI staff members (the Medical Training Director and the Inside Projects Officer) who, with suggestions and a mandate from the MCI board in Quetta, undertook a lengthy trip through nine southwestern provinces of Afghanistan from December 1986 to February 1987. A general health needs assessment was carried out during this journey. Another similar trip is to be undertaken by the Inside Projects Officer to Zabul and Ghazni in late July 1987.

The hospitals in Herat and Helmand (which are staffed with doctors) are of necessity heavily protected and are located in mountain caves, while clinics (which have no doctors) are set up in mud buildings; mobile units are on the move in areas of heavy fighting. At present, major party affiliations of these facilities embrace these groups: Jamiat, Harakat, Nejat, Mahaz, Hezbi (Gulbuddin) and Hezbi (Khalis). Individuals are now nominated by commanders through the parties for MCI training in groups; when they return to their localities, these young men then work together as a team.

There are three points of entry along the border which are utilized by MCI students and staff: Rabat in the west, Chaman north of Quetta and Badni in the east (Map B, Page 49). When students complete coursework, they are accompanied to the border by their party representative and MCI staff representative, and it is here that they receive their medical supplies and medicines; necessary documents are signed and they set off for their homes inside Afghanistan.

Travel in the southwestern portions of Afghanistan is somewhat different than that in the eastern sectors of the country. Open deserts and plains areas provide less security than mountains, but also allow for utilization of trucks and other motor vehicles under the cover of darkness. In mountainous areas farther from the border, animal transport is used.

In MCI classwork, students are instructed as to how to keep concise clinic records and how to communicate with the MCI Field Office in Quetta; preferably this is to be done monthly in writing, although this varies according to accessibility of clinic area and other considerations. They are also instructed in how to develop relationships with the community in which they serve. For each health facility a local shora-i-clinic (clinic council) is established, which is composed of all clinic staff, a civilian leader and the primary representative of the local mujahiddin group in the region. This council coordinates with the communities in the regions, hears any complaints or problems and relates clinic progress and activities in writing to the MCI office in Quetta. In addition, every three months a representative from the Quetta office is to visit the health facilities to monitor progress.

(4) Coordination between MCI Activities in Pakistan and Afghanistan

The MCI organizational structure possesses potential for increasingly positive communications and coordination between training activities in Pakistan and field activities within Afghanistan. The Afghan Inside Projects Officer works closely with the Afghan Medical Training Director, whose many tasks in hospital administration, training coordination, etc., will be lessened when (and if) the new technical expatriate staff arrives. As this complex project continues to develop, the Country Director must work to assure that the various branches of General Administration, Training, Hospital Administration and Inside Projects meet regularly, work together and provide relevant information to one another in order to assure effective cross-border assistance.

c. MCI Coordination with Other PVOs, CMC (Coordination of Medical Committees) and AID/REP Office

MCI is isolated in Quetta and to date has had little communication with other PVOs involved in similar health-related activities which are based in Peshawar. The staff is making some use of IRC's (International Rescue Committee's) Health Education Resource Center for translation of a laboratory manual[8].

8 IRC staff in Peshawar at the Health Education Resource Center note that communications with Quetta are extremely difficult. IRC is considering establishing similar service in Quetta in the future.

MCI is interested in coordinating with other organizations and looks forward to participating in CMC (Coordination of Medical Committees) as a full member[9]. With CMC based in Peshawar, this would entail considerable travel by an appointed MCI representative to attend meetings periodically and the staff acknowledges that this would be time-consuming. However, MCI recognizes that it requires assistance in standardizing its training curriculum, needs basic texts and wants to standardize its salaries for staff inside Afghanistan.

In Quetta MCI does have informal communication with a number of other health-related institutions relating to Afghans; these include IRC, Mission Hospital, Ansari Hospital and the newly-established Malalia Afghan Women's Hospital. Indeed, MCI has distributed $200,000 in donated medicines to these organizations, along with $117,000 distributed by MCI to Mission Hospital, IMC, FM and MSH in Peshawar.

As a PVO beginning its activities somewhat later than others reviewed here, MCI has entered the cross-border assistance arena after the establishment of the AID/REP office and the arrival of the Health Project Officer. MCI is conscientious about contract obligations and communicates frequently with the Health Projects Officer in Islamabad by telephone, and with monthly staff visits to the capital to review their work. Its quarterly reports are submitted on time and are carefully prepared to address AID/REP concerns.

d. Recommendations

1) Continuing effort must be made in recruiting until the key expatriate technical posts of doctor and nurse/administrator are filled. MCI should also increase efforts to find skilled Afghan translators in Quetta or, if this proves impossible, in Peshawar and Islamabad.

2) As the Al-Jehad Training Hospital begins to function, training activities and surgical patient care activities must be clearly defined and coordinated. Detailed job descriptions for all staff should be prepared.

3) The system of communications with health facilities inside must be perfected. The shula-i-clinic (clinic committees) are important in that local communities are involved and their formation and function should be monitored.

9 CMC is an organization formed by cross-border health PVOs themselves in Peshawar. All of the PVOs reviewed here are associated with the group.

4) As MCI activities develop in complexity, both in Pakistan and Afghanistan, staff in Quetta should have more general strategy meetings in which information is shared and progress, problems and future plans of each subsection of the office are discussed. These should be held every other week. Every few months quarterly reports should be reviewed in detail.

5) MCI should send a representative to CMC meetings in Peshawar; in addition, the CMC Medical Director and Administrative Director should visit MCI in Quetta in order to better understand the role of this PVO.

2. Educational Component of MCI

a. Background

The educational component of the MCI project consists of two distinct training endeavors, including separate course objectives, curriculum contents and purpose. However, an interrelationship of teaching staffs and utilization of common facilities exists. Prospective students of each course are recruited, selected, trained, and eventually assigned though similar, yet separate, systems.

(1) First-Aid Training Program

The three-month training program is referred to as the First-Aid Course and is intended to provide trained first-aid workers for voluntary service to the mujahiddin and civilians inside Afghanistan. This course was developed and 17 classes have been offered since November 1981 under the auspices of Al-Jehad. In July of 1986, MCI and Al-Jehad merged this program within the MCI/AID project grant. To date, a total of 4 classes have been supported through this mechanism, three of which have concluded for a total of 88 graduates and a current class of 39. The number of admissions per course has continued to decrease since 1986, (59-52-42-39) while the number of graduates per course has remained essentially the same (28-31-29 in progress). One causative factor may be the more stringent entrance criteria for return potential. Students are no longer accepted if close family members have migrated to Pakistan. A slight increase of those said to be returning "inside" would seem to validate this assumption. Another factor may be reflective of greater selectivity, screening and increased entrance examination requirements from a 50% to 60% pass rate. The previous greater that 50% dropout rate has been reduced to 30-40% in the last two classes. The possibility also exists that the proliferation of first-aid classes offered by other organizations of shorter duration (IRC: two-day and one-month courses) may also have an impact on recruitment. The 88 graduates of the previous three courses were predominately from the regions of Kandahar, Rozgan and Zabul (60%), while the remaining graduates were from Ghazni, Herat, Farah and Ghorat (approximately 10% from each area). Of these 88 graduates, 57 are said to have returned. However, there are no verifiable statistics of the number currently remaining inside or their locations. Three have been killed.

(2) Medical Aide Training Program

The six-month Medical Aide Training Program is intended to provide trained medical assistants to staff-specific MCI-supported health care facilities within Afghanistan. Graduates will be assigned to these facilities by geographical preference/area and are recruited as a team. Professional guidance inside is expected to be provided by Afghan physicians or qualified nurses. This professional leadership is a requirement for the establishment of an MCI facility. The first group of 38 graduates has only recently completed the course, due to initial start-date delays and inadequate hospital facilities to successfully complete the practical and laboratory experiences. Nineteen have been assigned and have reentered Afghanistan[10]. As of June 14, a second class of 34 is currently in progress following a 2-month start-up delay due to overlap of the first course, recruitment difficulties of sufficiently-qualified and Board Council-approved students, as well as facilities for practical experience, which were under construction.

b. Facilities

(1) Teaching

The facilities currently used for teaching purposes include a classroom at the dormitory compound, another at the newly completed hospital compound and the use of the OPD and hospital for practical experience. The newly dedicated hospital complex is an ideal setting for both learning and practice. The current OPD is scheduled to be moved to an adjacent area. The total complex is dedicated to teaching health care providers, as well as service to patients. As presently designed, the classrooms, while adequate, are limited in size for the number of students. There is little provision for any activity other than lectures, and without audio-visuals students frequently cannot see blackboards and can only listen or write on their knees. A redistribution of the teaching schedule could allow for smaller classes and group activity.

(2) Service Delivery

Al-Jehad Hospital and OPD are joint projects of MCI and Al-Jehad. MCI is currently seeking a full time physician to provide the attending coverage for hospital patients. Consultants and surgeons from the local community will be used as specialists on case-need basis. The complex, when opened (approximately August 1st), will include a 30-bed hospital with a surgical suite, laboratory, x-ray, dispensary and support facilities.

10 Afghanistan facilities, staffing patterns and salary structure are found on page 55.

Five of the 30 beds are designated "women's ward". There is ample expansion space for the future. The criteria for hospital admission is focussed primarily on Afghan mujahiddin; however, will accept emergency cases of Pakistani and/or refugees. While there will be no charges to patients for services, custodial care patients will be referred to other hospitals. The emphasis will be on "teaching" types of patients. The OPD serves the Afghan community around Quetta; the limits set are 100-120 cases per day. Currently, they have a 30-40 case overflow daily. Triage/screening of patients and a number system is used for selection. Three physicians are currently assigned to this OPD area. Students of the three-month and six-month courses are provided experience in both hospital and OPD settings. The current OPD will be moved to a location adjoining the hospital complex and will share facilities of the lab, x-ray and dispensary.

c. Course Admission Criteria and System

The admission system for each of the two courses of study is based upon specific criteria and approvals. Several commonalities exist. Table 4 list specifics for both the three and six-month course. The major dichotomy exists in the recruitment/approval of students. Three-month participants are closely aligned to various commanders and are not assigned upon completion of the course to any MCI facility. Their eventual whereabouts, and independence of practice provides for problems of evaluation, monitoring and any degree of supervision. Six-month participants must have the approval of the Board Council Committee members. They are team or group recruited and eventual assignment is to MCI facilities as a team. The group team process of recruitment requires greater coordination efforts of MCI and the Board Council and frequent time delays are encountered. However, this approach appears to offer more stable methods for the future monitoring and evaluation of practice standards of teams/individuals as well as opportunities for communication and further knowledge development for the students. The established admission criteria has not been maintained due to an insufficient pool of qualified applicants. The result has been a lowering of standards to accommodate class size. Greater focus on recruitment and strategies to improve it are warranted for the future.

d. Curriculum and Methodology

(1) Six-Month Course

Significant changes in curriculum content and students training focus arose during the first course offering[11]. MCI staff decisions to re-focus the students toward specific specialty assignments followed a

11 Current curriculum content is listed in Table 5, (Course Structure - Certification and Assignment Specifics).

reevaluation of the needs and facility sites within Afghanistan conducted by two Afghan administrative staff. Based on their report and recommendations, each student was designated by the Al-Jehad and MCI staff to be developed as a specified assistant (surgical, x-ray, laboratory, medical or dispensary/dental), rather than the generic medical aide. The resultant change in student expectations and dichotomy of personal preferences resulted in a short-lived "student strike". Subsequently, the curriculum is being restructered to accommodate these changes. The current class has been apprised at the initiation of the course that mandatory assignment and tracking selection will be made by the teaching and administrative staff. These decisions are based upon the staff view of student capability and the numbers of each specific position required to staff a geographical location and facility. Personal preference will be a factor only when such an accommodation is possible. This assignment determination is made at the end of the first month "core" training period. As the second group has not completed this "core" period, the reaction/acceptance of this group to its eventual designated position cannot be currently determined. However, both staff and students express their belief that the least desirable position is that of medical (public health) assistant, and most desired is that of surgical assistant. Although all staff members reaffirm their stated goal is to train assistants to qualified health professionals, most privately express the belief that many students of both the three-month and six-month courses will become independent practitioners ("doctors") and such specific occurrences among three-months graduates are already known to some. The extent of this phenomena cannot be measured at this time. However, it is not unreasonable to predict that this trend will continue given the lack of health care providers and health care infrastructure within Afghanistan. Such a potential should be carefully considered in issues of curriculum content and evaluation issues related to students' education, achievement and practical applications.

The revised laboratory practical courses with the increased 50% to 70% pass requirement is reflective of MCI's concern for quality, in this aspect of its education process. The laboratory curriculum is appropriately focused toward the teaching of specific and limited essential, identified skills and intergrating information and extensive practice. It is further supported by a soon to be translated reference manual and comparative slide set development to minimize diagnostic error. Demonstrated proficiency of skills is measureable and provides a basis for a minimum 70% pass requirement. With curriculum refinement and further evaluation of the "problem areas" in the future, these students should be expected to increase their accuracy rate to a minimum 80% standard for the essential laboratory diagnostic areas required.

The remainder of the theory content of the course curriculum (with the exception of the laboratory practical components) is heavily oriented towards an overly detailed theoretical segmented approach primarily

consisting of lectures. Practical experiences do not occur until various individual theory subjects are completed. This format minimizes students' opportunities to intergrate knowledge with timely practical application/experience. In addition, the predominant lecture format, poor quality or lack of visual aids, no student textbooks and limited translations of lecture information both verbal and written, severly impedes the potential learning outcomes of these students.

This six-month course presents numerous educational challenges such as diversity of fundamental educational backgrounds of the students, cultural and language differences of instructors and students, absence of appropriate and acceptable texts, teaching models and audio visuals, in addition to an ambitious content array of "specializations"--all within a 6-month time frame. Such challenges are not likely to be successfully met by conventional professional health care education methods or format, and the quality of student performance can be seriously questioned (50% pass grade).

The accuracy of the present theory content is not at question. However, serious reconsideration by MCI of the necessity/appropriateness of the present level of extensive detail, limited classroom methodologies and limited integration of learning with practical understanding is warranted, particularly at this juncture while development of a curriculum and student materials is still in a relatively formative stage. In addition, a careful evaluation of the cost-benefit and capacity of MCI to "produce" quality students in multiple "specialities" should be done (i.e., x-ray), particularly in view of the very limited numbers of these personnel required.

(2) Three-Month Course

The curriculum content of the course has virtually remained unchanged with the exception of the addition of English (48 hours) and Humanitarian Principles (8 hours) decreasing the number of hours of other content areas respectively[12].

A vast array of subject matter, while appropriate in terms of inside application needs, is dealt with too briefly to assure any modicum of practical understanding or quality assurance of future practice (pharmacology, public health, vaccinations, communicable diseases, etc.). The supplemented and advanced first aid subjects are appropriate, but need to be supported by enhanced and specific planned practical experiences for each and every skill taught. The majority of these skills will not be practiced in a clinic or hospital setting, but under field conditions and should be perfected for such an environment through repetitive supervised practice or field exercises.

12 Curriculum content is listed in Table 5 (page 53), (Course Structure-Certification and Assignment Specifics)

The actual number/whereabouts of previous graduates serving inside is questionable. In view of the more structured system for use and accountability of the six-month graduates, as well as the availability of other short-term first-aid courses, MCI should seriously consider consolidating its educational focus toward one quality program.

e. Educational Administration and Faculty

The administration of the education component of the MCI program is not clearly defined. Both Afghan and expatriate staff serve in several capacities and the relationships and roles between Al-Jehad and MCI are somewhat different in practice than defined in organization charts.

There is no one individual who has overall specific responsibility for the direction, development and management of the two education courses.

A multipurpose "curriculum committee" has been formed to address numerous issues. However, it functions as a general oversight group for the many aspects of the total project which may include some education/curriculum issues. For the most part instructors meet ad hoc and separately from this group. While such a group as the "curriculum committee" is necessary for overall project coordination, it cannot deal in sufficient depth with the large undertakings/needs for curriculum and materials development, design, translation and delivery.

The limitations in number and type of staff severely inhibit the capacity of MCI to formulate cohesive educational strategies and develop and administer two instructional programs of the complexity it envisions, while also administering the new service delivery facilities simultaneously.

Instructors are essentially working in isolation developing and delivering their lectures with limited consideration for integrating theory with practice or for pre-identifying just what needs to be learned and when. Most of them have "never done this before". While dedicated and committed, they are working under severe handicaps of language, lack of tools, and materials, teaching experience or knowledgeable educational leadership direction.

MCI should seriously consider an education director position. The current structure, even with the filling of much-needed other positions, will not sufficiently address its education problems.

In addition, due to its location, MCI has not taken advantage of the "lesson learned" or the resources information sharing derived from other PVOs of the CMC group. The differences in language, poor recruiting, number for selection and diminished educational backgrounds of students from the areas served by MCI are also significant handicaps. Very few Afghan health professionals or quality translators have been found.

Pakistani health professionals of this staff also require a translator in classes and the quality of translated information being delivered is very questionable.

Students have nothing to read or see that will correct or build on the limited information they are filtering from overly didactic, poorly-translated detailed theory and, to date, there is no significant opportunity to practice most of the skills they will need to perfect.

f. Educational Program Recommendations

1) Seriously evaluate MCI education substructure and include a well-qualified director of education position for the overall planning and development of the education program and a small curriculum subcommittee to deal only with education issues.

2) Reevaluate theoretical content level for appropriateness/need. Identify essential information and skills required. Build curriculum base around only the essential knowledge and skills required. Integrate practice throughout course.

3) Obtain quality translations of all materials and provide students with copies or composite reference manual.

4) Change the three-month first-aid course to a one-month pre-requisite to the six-month course. The one month course should cover essential first-aid skills only.

5) Incorporate additional teaching methods, such as use of demonstrations or small group practical exercises, to decrease lecture formats and reinforce understanding.

6) Reevaluate need and cost-benefit of training x-ray technicians.

7) Develop and implement specific skills list system to monitor each individual student's performance, completion and level of achievement.

8) Further enhance visual and practical teaching tools (i.e., oversized anatomical systems charts, flannel boards, slides, models or demonstrations/practice dolls).

9) Develop/strengthen strategies to recruit and develop additional Afghan professionals as instructors and translators.

10) Seek closer cooperation with other PVOs and CMC for resources sharing and coordination.

11) Improve student recruitment procedures and mechanism to provide a larger selection pool.

12) Develop specific job descriptions for instructors/trainers to assist in advance recruitment and selection, particularly of expatriate staff.

13) Improve home office support of recruitment system and field supply needs.

3. Monitoring and Evaluation Component (M&E) of Mercy Corps International

a. Overview

MCI's proposals and quarterly reports refer to the importance of monitoring and evaluation and its intended use as an integral part of its operations. Although MCI refers to its approach as focusing on formative evaluation (which usually means one or two mid-term evaluations), its strategy appears to be more of an ongoing series of mini-evaluations of the various training activities at Quetta as well as on the performance of students inside.

During this first year of MCI's life, a number of evaluations and assessments have been conducted. They have been very well focused, driven by a need to identify effective approaches, problem areas and gaps, and the resulting data has been strategically used to make decisions on program modifications. They have clearly demonstrated an understanding that close and frequent monitoring of MCI's activities flags problems as they arise and permits quick corrective action.

MCI's reporting of data has been outstanding. Promptly at the end of each quarter, MCI has submitted a quarterly report to the AID/REP that is well written and highly informative. Each quarterly report is divided into two major sections: Administration and Medical Assistance. In each section, the objectives to be achieved during the quarter are clearly stated and followed by a detailed description of progress made toward each objective, any problems inhibiting progress and a full explanation of any modifications made in the activities intended for achieving the objective.

To date, MCI has been extremely responsive to the AID/REP's need for information. Such reporting has assisted the AID/REP in monitoring its activities and in providing the kind of management needed for all projects.

Presently, MCI has no overall formal, written strategy for monitoring and evaluation. Much of the data collection tends to be departmentalized and directed to individual activities. While this informal approach to M&E has served its management information needs sufficiently so far, MCI may find at some point that it has missed an opportunity for collecting some very important data upon which critical decisions could be made.

The following sections contain a detailed description of how MCI is or intends to monitor and evaluate training, clinics and staff. Also included are some examples of data collection efforts and assessments conducted to date.

b. Training

MCI has conducted a number of discrete evaluations on its training program. Following are some examples.

Student Examinations

MCI tests three-month students every two weeks. Students who fail two consecutive tests are dropped. At the end of eight weeks of classroom instruction a final oral and written exam is given. Those attaining 50% marks or better pass the course and go on for four weeks of practical training after which they are again tested. Students in the six-month classes are tested weekly.

During interviews with six of the teachers, all but one said they did in fact give students bimonthly exams and, in some courses, students were given daily exams. Only one of the teachers said he/she gave no exams during the six-months and couldn't say what skills had been developed at the end of the course because skills were not tested. When queried why exams were given, the teachers explained that the exam results were important for informing them of what material the students were having difficulty grasping, thereby guiding them on what points needed further clarification. Thus, the use of exam results transcended mere judgment of who passed and failed but was used for an additional and critical purpose: to guide the daily lessons taught.

Curriculum Committee

Another mechanism used to evaluate and make decisions regarding training activities was the establishment of a Curriculum Committee. This committee holds weekly meetings to deal with course-related problems as well as to refine and improve upon course organization and the teaching process.

The Curriculum Committee has tackled such issues as determining the optimum balance between theory and practical training and how students should be chosen for their specialization. The Curriculum Committee also took on the major task of delineating clearly-defined objectives for the students in their areas of specialization. A subcommittee was set up to determine enabling objectives in curriculum development and clinical training. When specifically defined these objectives will serve as a basis for evaluating the students' accomplishments, as well as to direct MCI inspection teams who periodically visit the health care facilities in Afghanistan to ascertain students' effectiveness as health care workers in the field.

Report Cards

A new data collection instrument has recently been designed to further assist MCI in keeping track of six-month students' progress during their training in Quetta. This new instrument is a student record that keeps track of comments from teachers as well as the dorm administration. Because this is a new method of evaluation, the team could not assess its effectiveness.

Course Effectiveness

MCI staff conducted an informal evaluation of the effectiveness of the six-month course to identify areas that needed changing. This evaluation was based on reviewing teachers' experiences with the students through the six-month period, the level of students' skills developed by the end of the training and students' complaints. One major outcome of this evaluation was a change in the balance of theory and practical training. During the first six-month training, the ratio was 50:50. This balance changed for the second six-month class to 40:60 with a greater stress on practical training. MCI plans to repeat this informal evaluation in November when the second session is over to determine where further refinements are needed in the training.

Clinical Practice

At the beginning of its program, Mercy Corps International had an agreement with Ansari Hospital to accept students for clinical rotations. With the arrival of the expatriate volunteer lab technician and nurse practitioner in February 1987, an assessment was made to determine if Ansari was the best learning environment for practical training.

The assessment revealed that the quality of patient care was substandard due to a lack of trained staff, limited medical equipment and supplies and low sanitation standards. The patient mix of cases was poor for providing enough clinical learning situations for the students. This, as well as poor organization of students in the wards and OT, meant that students were not being trained as intended. The Ansari staff were simply not spending enough time teaching students nor were they identifying opportunities for students to perform under supervision the various medical procedures they were supposed to practice. The planned for 50:50 theory and practical experience did not occur.

One option for MCI was to upgrade Ansari by providing large amounts of resources. MCI realized, however, that it had no real leverage over Ansari and after such upgrading, Ansari could always ask MCI to leave. Based on the findings of this assessment, MCI decided to terminate its arrangements with Ansari and direct its resources to upgrading the Al-Jehad facility to a fully operational surgical hospital. Because this

assessment was accomplished so early in MCI's life, it was able to identify a major weakness in its training in time so that the practical training of students would not be compromised in the future.

However informal MCI's M&E strategy has been, the evaluation team believes it has done an excellent job in closely evaluating the quality of its training during its first year.

c. Clinics

Within the first six months of MCI's operation, two of the senior Afghan staff went inside Afghanistan to check proposed clinic sites to determine their suitability (e.g., existence of appropriate medical personnel, relatively secure location, medical needs). This two-month inspection visit inside Afghanistan turned into a comprehensive needs assessment which dramatically altered MCI's training focus and clinic plans inside Afghanistan.

The major conclusion arrived at during this assessment was that medical needs were not uniform in the regions visited. In areas of heavy fighting such as Kandahar and Herat there was a great need for surgical facilities. Areas away from the major fighting zones had little need for surgical help but a great need for OPD facilities. Thus instead of establishing only a few surgical clinics as planned, MCI decided that a greater number of OPD units of varying size should be set up in populated areas.

As a result of this evaluation, MCI developed a new plan for medical facilities with its respective personnel and equipment requirements. Because OPD services emerged as a significant need throughout the areas visited, the training focus shifted from being primarily emergency medicine to a more appropriate balance between public health and emergency care.

With most of the first six-month class having returned to Afghanistan to staff clinics, MCI staff has formulated some informal plans to conduct an "inspection visit" of a few clinics approximately every three months. These visit, conducted by one or both of the Afghans that made the initial assessment, will involve reviewing the everyday running of clinics--are staff working according to "criteria", how are their relationships with the surrounding community, etc.?

The evaluation team commends MCI for planning such regular monitoring of its clinics by two of its senior Afghan staff and believes it will collect important information on the running of the clinics. At the same time, neither of these individuals proposed for the assessment are medically trained and realize they are not qualified to assess the students' ability to adequately deliver quality health services. Because of this considerable gap in evaluating clinic effectiveness, MCI is

toying with several possibilities. It is considering bringing in health experts periodically to assess students' performance or asking visiting journalists to inspect its clinics and identify weak points without the clinics being aware of their mission. These are all in the idea stage and, at present, there is no plan to systematically collect "performance" data on the students in the clinics which would be priceless information for identifying weaknesses in the curriculum.

Several data collection forms have been designed for use in the clinics, such as:

1) Disease Form containing a listing of diseases and their prevalence among the populace.

2) Medical Supplies/Medicines Form used to determine what needs to be resupplied.

3) Clinic Counsel Reports, prepared by the counsel which consists of clinic staff, the commander and civilian leaders, involves subjective evaluation of all of the clinic activities including local population input.

4) Salary Record includes the number of days present and absent for each worker and the worker's signature to acknowledge receipt of the salary.

5) Warehouse Form lists those medicines and medical supplies taken inside Afghanistan.

During the six-month course, all students receive training in how to complete these forms.

d. Staff Evaluation

MCI's approach to monitoring and evaluating expatriate volunteer staff effectiveness begins during the recruitment phase with intensive interviewing and testing prior to being hired. Volunteers submit to two interviews and psychological testing to predict their potential effectiveness and appropriateness.

The Quetta staff communicates regularly with the Portland home office with regard to all field or personnel issues.

At this point, MCI/Quetta has not developed a formal plan for evaluating its teaching staff. Some informal evaluations of staff have been conducted, mostly on an ad hoc basis.

e. Recommendations

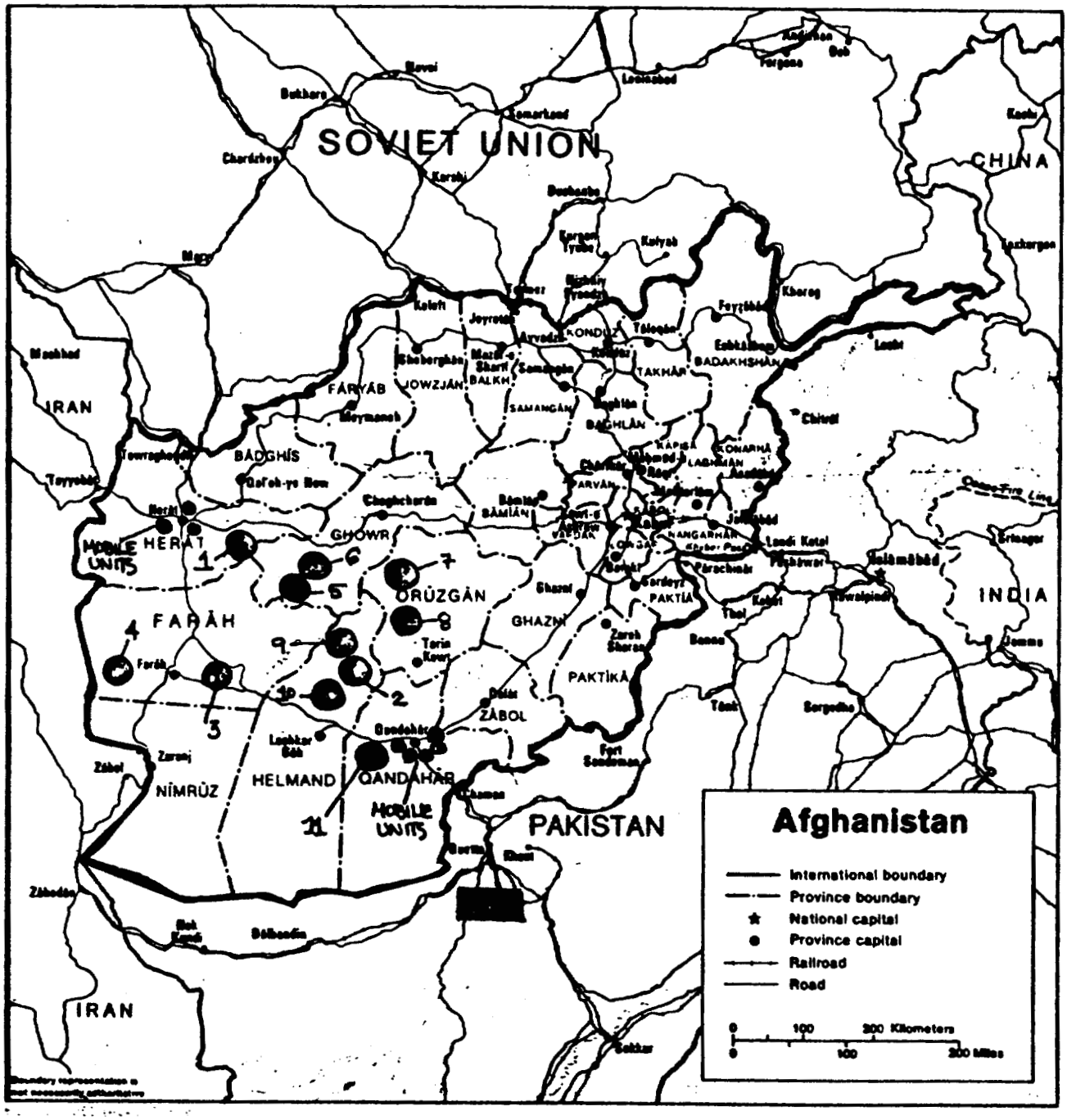
1) MCI should develop an overall written strategy for M&E. Data needs should be established for all current and future activities. The plan should be specific, with adequate detail for guiding implementation, management-oriented, user-driven and geared toward the "minimum necessary".

2) MCI should conduct medical assessments of its clinics inside Afghanistan on an annual basis. MCI should make necessary efforts in conjunction with CMC to accomplish this.

3) Data collected should be reviewed annually to determine their utility for problem-solving and decision-making.

4) After each quarterly report is prepared, the entire MCI staff should meet to review findings and develop a plan of action for addressing problem areas identified.

MAP B: HEALTH FACILITIES OF MERCY CORPS INTERNATIONAL (MCI)
IN AFGHANISTAN
(July 1987)



*Numbers refer to Table 2.

TABLE 2

HEALTH FACILITIES IN AFGHANISTAN
MCI - MERCY CORPS INTERNATIONAL

As of July 1987

11 fixed units
8 mobile units

- - - - - - 2 hospitals - - - - - - - - - 9 OPDs
1 doctor

5 near Kandahar
3 near Herat

6 A-Level units (has laboratory)

3 B-Level units (no lab; nearby)

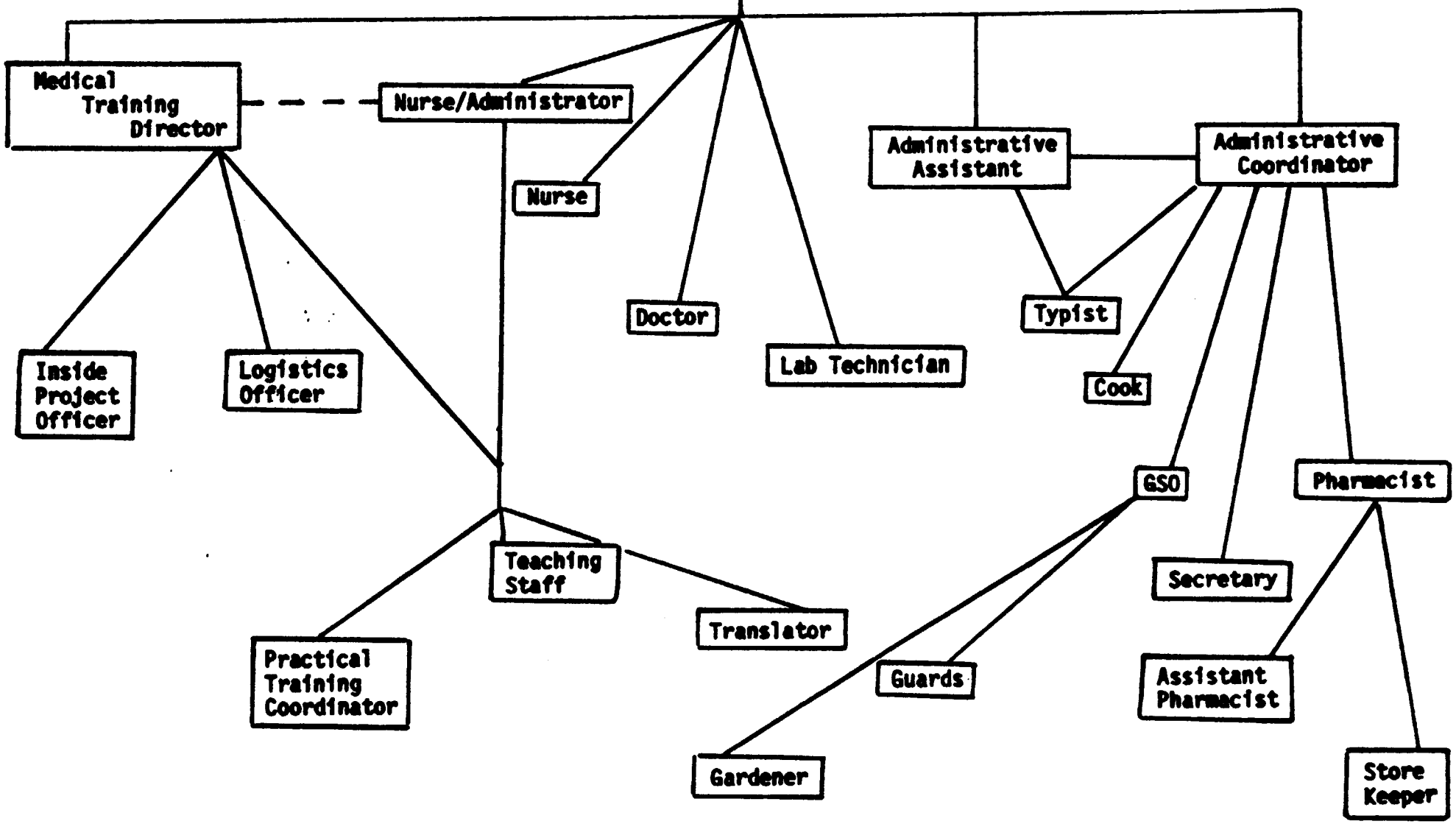
	Province		Village/Town	Party Affiliation
HOSPITALS	1. Herat (3 doctors) Hatim-Al-Anbia		Toghan Koh (District Pushtun Zarghoon)	Jamiat
	2. Helmand		Kalat-i-Baghni	Hezb (Gulbuddin)
OPDs	3. Farah	1 A-Level	Sharafat Koh (Fararod)	Mujadedi (Nejat)
	4. Farah	1 B-Level	Anardara	Mujadedi (Nejat)
	5. Ghorat	1 A-Level	Chardar (Taiwani)	Harakat
	6. Ghorat	1 B-Level	Tshchmai-Muran (1 day away)	Harakat
	7. Orozghan	1 A-Level	Kijran Bazarr	Mujadidi
	8. Orozghan	1 B-Level	Khud Valley (1 hr. by car)	Mujadidi
	9. Helmand	1 A-Level	Baghran (in District Center)	Harakat
	10. Helmand	1 A-Level	Musa Qala	Harakat
	11. Kandahar	1 A-Level 1 B-Level	Sang-i-Hisar (40 km west of Kandahar city)	Harakat
MOBILE UNITS				
HERAT				
1. Siawooshan			(Near Herat City)	Jamiat
2. Kamizan			"	Jamiat
3. Dogh Abad			"	Jamiat
KANDAHAR				
1. Mabtajat			(Near Kandahar City)	Nejat
2. Tulagan			"	Hezb (Hikmatyar)
3. Spirwan			"	Mahaz
4. Shoeenan			"	Mahaz
5. Tabeenan			"	Herb (Khalis) (See Map A)

[redacted]

LIMITED OFFICIAL USE

MERCY CORPS INTERNATIONAL: (MCI) ORGANIZATION CHART

TABLE 3



LIMITED OFFICIAL USE

TABLE 4

MERCY CORPS INTERNATIONAL

MCI - Admission and Retention Criteria

3-Month First Aid Course

Recruitment: Introduction and guarantee by Commanders of individuals.

Criteria
Admission: *7th grade/equivalent minimum education requirement.
*60% pass grade entrance examination (increased from 50%)
*Non-migration of immediate family members.
Retention: *Class examination every two weeks.
Two consecutive failures - dropped without warning.
*Final theoretical exam end of 8 weeks.
50% pass grade. Required to continue to 4 week practicum.

6-Month Medical Aide Course

Recruitment: Introduction and approval of MCI Council Board of party members of geographical groups of students. 3-6/Group.

Criteria
Admission: *Graduate of 3 month. first aid course prerequisite of original project proposals. Not adhered to criteria dropped.
*70% pass grade entrance exam proposed.
50% pass grade accepted to fulfill class numbers and group makeup.
*Screening interview.
Non migration of immediate family members.

Criteria
Retention: *Variable class examination schedules dependent on instructors, throughout theory content.
*Exam at end of "core" 144 hours. 50% pass grade required to continue - all students.
*Final exam for all non-laboratory students at completion of 2nd 144-hour theory phase. 50% pass grade required.
Laboratory students interim exams weekly throughout laboratory practical course.
*Final theory and practical exam at conclusion

TABLE 5

MERCY CORPS INTERNATIONAL

MCI - Course Structure and Assignment Specifics

(Page 1 of 2)

Course: FIRST AID - 3 Months

Subject Areas	Hours of Instruction	Instructor	Methodology	Student Materi
English	48*	MCI Teacher (Ex-patriot)	Lecture	Instructor developed "hand
Humanitarian Principals	8*	ICRC Delegate	Lecture	ICRC materials & aid reference t
Medical Subjects *Anatomy & physiology *Communicable diseases * Shock *Heatstroke & heat exhaustion *Frostbite *Drowning *Snake and insect bites *Pharmacology *"Public Health" Vaccinations	30*	Physician (Afghan)	Lecture	Translated spec textbook. "Jamiat-Al-Ul of Afghanist Al-Jehad Hospi First Aid Train Textbook for Fi Aid Nurses"
Surgical Subjects *Trauma *Infection *War wounds *First Aid *Surgical techniques *Transportation techniques	60*	Surgeon (Pakistani)	Lecture and Demonstration	
Practical Training *Injections, dressings *Fracture immobilization *Health education & hygiene	96* 3*	Nurse (Pakistani)	OPD & Hospital observation & practice	

- Graduates called "First-Aid Nurse". Work independently in the field--attached to commanders/ mobile units. Relate to OPD's/hospitals as referral/transport receiver.
- Certificate given after 1 year of service "inside"--compensation $60/month.
- Oath statement signed on completion of course.
- Supplies and pharmaceuticals provided at border at time of entry.
- Resupplied by written verified request of worker and commander.

TABLE 5
(Page 2 of 2)

MERCY CORPS INTERNATIONAL

MCI - Course Structure and Assignment Specifics

LIMITED OFFICIAL USE

Course: MEDICAL AIDE - 6 Months

Subject Areas*	Approximate Hours of Instruction	Instructor	Methodology	Student Materials
Learning Theory	4°	MCI Lab. Tech. (Ex-patriot)	Lecture	Exercise "handout"
English**	40°	MCI Teacher (Ex-patriot)	Lecture	Instructor developed "handout"
*Laboratory Techs.	24°			
Anatomy & Physiology	48°	Nurse (Pakistani)	Lecture	
Bio-chemistry	24°	Physician (Afghan)	Lecture	Translated lecture notes of instructor presentation each session
Pharmacology**	24°	Pharmacist (position open)	Lecture	
*Laboratory Techs.	0			
Administrative practices	8°	Administrator (Afghan)	Lecture	
Health Care & Culture**	8°	MCI Teacher (Ex-patriot)	Lecture	
*Laboratory Techs.	0			
Preventive Health Care	16°	MCI Lab. Tech. (Ex patriot)	Lecture	
Internal Medicine**	48°	Physician (Afghan)	Lecture	Translated lecture notes of instructor presentation each session
*Laboratory Techs	24°			
Nursing theory**	144°	Nurses(3) (Ex-patriot) (Afghan) (Pakistani)	Lecture	
*Laboratory Techs	0			
Clinical Experience**				
*Medical Aides	444°	Nurse (Afghan)	Demonstration & practice	OPD/hospital rotation experience
*Laboratory Techs.	720°	MCI-certified laboratory tech. (Ex-patriot)	Lecture, Demonstration & practice	Laboratory slides, manual translated & specific to practical application focus.

- Graduates called Medical Aides (Assistants)/Laboratory Tech with further specification of Medical Aides as: 1) Surgical Assistant; 2) Dispensary-Dental Assistant; 3) X-Ray Assistant; or 4) Medical Assistant.
- Certificate given after 1 year service "inside"--compensation: $100/month.
- Written contract signed with MCI.
- Assigned to designated facilities--work under supervision of qualified professional (physician/nurse) at facility.
- Supplies, equipment and pharmaceuticals provided to facility staff at border at time of entry, based on type of facility assigned.
- Resupply by written verified request of facility administration.

*Subject areas differ for Laboratory Assistants.
**Major subject areas.

LIMITED OFFICIAL USE

TABLE 6

MERCY CORPS INTERNATIONAL

MCI - Proposed Staffing Patterns Afghanistan Facilities

Type of Staff	Minimum # of Staff/ Hospital	Minimum # of Staff/ A-Level OPD	Minimum # of Staff/ B-Level OPD	Minimum # of Staff/ Mobile Unit	MCI Trained Graduates # of Staff Proposed	- Assigned
Professional						
Physician	1					
Qualified Nurse		1	1			
Graduates MCI						
"Lab Technician"	1	1			18	
"X-Ray Technician"	1				6	0
"Dental/Dispensary"	1	1	1		28	
Medical Aides	3				18	
Surgical Aides	3	1	1		140	
Mobile Unit First Aiders				1-2	18 16-32	57*
Other						
Guards	2	2	N/A	0	--	--
Clerk	1	1	N/A	0	--	--
Cook	1	1	N/A	0	--	--
Sweeper	1	1				
Drivers	2	N/A				

N/A - Not Available

July 1, 1987

TABLE 7

MERCY CORPS INTERNATIONAL

MCI - Afghanistan Facilities

Province	Hospital		A-Level OPD**		B-Level OPD**		Mobile Units	
	Actual	Additional Proposed	Actual	Additional Proposed	Actual	Additional Proposed	Actual	Additional Proposed
Badghis				1		2		
Herat	1	1					3*	
Ghorat				1		2		
Farah			1		1			
Helmand	1		2			1		
Kandahar		1	1	2		1	5*	
Rozgan			1		1	2		
Zabul		1		1				
Ghazni		1		2				
Total in Place	2		5		2		8*	
By 5/1/88 Total Additional to be Established		4		7		8		0*

*Continuing functioning of units non-verifiable--Resupply has not as yet taken place.
**Differentiated by laboratory service staff and supplies.

TABLE 8

MERCY CORPS INTERNATIONAL

Salary Structure Afghanistan Facilities

Personnel Category	Current Salary	# Currently Employed
Professional Staff	$	
Physician	200.00	0*
Qualified Nurse	150.00	0
MCI Graduates	$	
3 Mo. First Aiders	60.00	0**
6 Mo. Medical Aides All Classifications	100.00	11**

*Have committed to start up funds, but to date have not received expense requests Herat and Helmand (physicians).

**Salaries not implemented until "inside". Student graduates enter at variable intervals. Additional graduates of recent course to leave shortly (July).

B. International Medical Corps (IMC)

1. Introduction to IMC

a. Location, General Objectives

IMC was founded in 1984 by Dr. Robert Simon, Assistant Professor of Medicine at the UCLA Emergency Medical Center, for the explicit purpose of providing medical assistance inside Afghanistan. Prior to AID/REP funding, IMC had set up three small clinics in the southwestern section of Afghanistan with donated funds from the USA.

IMC presently trains Afghan advanced surgical medics in Pakistan who return to Afghanistan to work in IMC-supported health facilities. Emphasis is upon providing assistance to far-flung regions of the country rather than just to the nearby border areas, whose populace it is assumed have better access to health care. Although initial concern was with training surgically skilled medics to deal with the war-wounded, recently a more general approach towards civilian health care has been taught.

At present IMC carries out an eight-month training course in its Nasir Bagh Training Center which is located near a large refugee camp in the western suburbs of Peshawar. The first class began in January 1986. To date, a total of 128 trainees are in various phases of training.

Inside Afghanistan IMC now supports 29 health facilities scattered thoughout the country in which graduates of the training course work; these include 3 hospitals (in Balkh, Faryab and Herat) and 26 clinics (Map C, Page 68).

b. Organizational Structure and Function

(1) IMC Office in Pakistan

The IMC office in Pakistan is comprised of eight expatriates (one Director of Operations and seven technical staff), 52 Afghans and one Pakistani physician. The expatriate Director of Operations is responsible for general administration and management, the expatriate Medical Director deals with training and health care delivery in Pakistan and the Afghan In-Country Director is responsible for cross-border activities inside Afghanistan. IMC also has a highly-skilled cadre of eight Afghan translators on the staff.

There is a high degree of turnover among the technical expatriate staff, with sometimes no overlap between tours of even key staff such as Medical Director; many individuals chose to work for only short periods of three months. This leads to lack of consistency in training activities and in general project development.

During the evaluation team's visit to IMC, the Director of Recruiting from the Los Angeles office was in Peshawar on her annual visit, to ease the transition from one Medical Director (who left due to a knee injury) to another who arrived a week later. She stressed that recruiting of staff was not a problem per se; with a membership of 2000 and an effective advertising campaign, IMC can recruit new staff quite quickly but few individuals can stay for longer than a few months.

(2) Relations Between Home Office and the Field

Communication between the Los Angeles home office's Executive Director and Peshawar's Director of Operations is regular and includes correspondence, phone calls and a weekly modem computer link.

Although day-to-day decisions are able to be made in the field, in conversations with the Director of Operations, it became evident that reports generated by the Los Angeles home office often contain data analysis and future project plans which are unfamiliar to the field staff. Reports often differ from actual activities.

Major decisions concerning the project must be first approved by the home office. It appears that in the past this lack of delegation of authority led to poor relations between the field director and the home office.

The IMC Board of Directors directs how medics should be trained. Any changes desired by the field staff must first be approved by the Board. This can be time-consuming, along with causing some hard feelings between home and field staff.

(3) Coordination with Afghans in Pakistan and Afghanistan

(a) Afghan Parties, Commanders and IMC

All candidates for IMC classes (there have been more than 400 applying for recent sessions), must be appointed by commanders inside Afghanistan and subsequently nominated by one of the major parties in Peshawar. Each individual must also have a formal letter from the Alliance Health Committee. The Director of Operations and In-Country Director meet with commanders who frequent Peshawar. In addition IMC has provided medicines to Pakistan-based health facilities of Jamiat, Nejat and other parties.

(b) General Framework for Service Delivery in Afghanistan

Table 9 (Page 69) provides a listing of IMC health facilities active inside Afghanistan as of July 1987. Three hospitals are located in the far north and west (Balkh, Faryab and Herat), with 26 clinics scattered across some 17 provinces (Map C, Page 68). Locations for sites must be in populated "free" areas which are relatively secure from attack.

The IMC service delivery system is well organized and is functioning as well as can be expected under difficult conditions. The knowledgeable Afghan In-Country Director receives periodic reports from local commanders, who are responsible for clinic security. Parties represented include Jamiat, Harakat, Mahaz and Hezbi (Gulbuddin).

Usually a team approach is employed, with two IMC graduates working at a clinic, although this is not always the case. Each graduate is given five months salary before going inside (2000 Rs/month or 10,000 Rs total) along with a necessary compendium of supplies (16 large bundles each). There is no set schedule for resupply of medicines or for graduates return visits to Peshawar. Resupply is done according to each clinic's record book which includes: (1) a green medical record in which daily expenditure of medicine, type of patient seen, diagnosis, etc., are recorded and (2) a yellow surgical record book for wounded patients. Some may stay in Afghanistan for three months before returning with their record books. At this time, the graduates are debriefed in detail by the In-Country Director; others stay longer and send out their record books for review and resupply.

IMC staff is concerned about the monitoring of its graduates in the field and employs five monitors who perodically visit their facilities. This is a difficult job, and they are not entirely pleased with this system; feedback is intermittent and they cannot verify quality of care being delivered. To rectify this problem IMC has asked that when the AMI physician evaluation team goes into northern Afghanistan in late July, the team also assess IMC facilities.

Data has been assembled from the record books, of which 40 green books and 15 yellow books have been received to date; in the field this is the task of one of the Afghan physicians on the team. In brief this data show that approximately 55-60 patients attend each clinic daily, with the hospitals receiving approximately 100; almost 75% of those attending are male. Data is sent to the Los Angeles home office for more detailed analysis, where a special Medical Research Coordinator may be hired.

(4) Coordination Between IMC Activities in Pakistan and Afghanistan

Staff meetings are held perodically by the Director of Operations for both Pakistan-based staff and those more directly involved in cross-border activities. With the initial data analysis of clinic records from Afghanistan being conducted by local staff who are also involved in training activites, valuable exchange of information is achieved.

c. Coordination with Other PVOs, CMC (Coordination of Medical Committees) and AID/REP

IMC students are sent to MRCA (Medical Refresher Course for Afghans) for further training in dentistry, physiotherapy, etc. In addition, IMC has supplied MRCA, Freedom Medicine, AMI and other PVOs in the Peshawar area with medicines in the past. And, as mentioned above, an AMI team will be evaluating IMC clinics in northern Afghanistan in July/August. Thus, in spite of some reticence expressed earlier on the part of ICM's home office towards coordination with other groups, IMC now works well with other health PVOs.

IMC is an active participant in CMC, and its staff strongly supports standardization of curriculum, manual development and analysis of research. It was suggested by IMC staff that perhaps CMC and MSH could further coordination between various Afghan parties in the future, which would also assist IMC in its work.

Progress reports are submitted quarterly to AID/REP which contain considerable data.

d. Recommendations

1) Efforts should be made to recruit expatriate technical staff who are willing to stay for six months or one year in order to provide more continuity to training activities.

2) A better relationship between home and field office should be developed, and the field staff should be given more decision making power in such areas as curriculum, manual revision, etc.

3) As much data analysis as possible should be done locally, with findings feeding back into the program immediately---rather than sending data to Los Angeles for assessment. If a Medical Research Coordinator is to be financed, this individual should be based in Peshawar.

4) IMC's interest in monitoring should be encouraged, and more teams such as the AMI evaluation mission to Afghanistan should be supported by CMC.

2. Educational Component of International Medical Corporation (IMC)

a. Background

The first medic training program established by the International Medical Corps (IMC) began in January 1986. This initial program consisted of two classes (advanced and basic) which were shortly merged into one due to the similarity of educational needs of both groups. As initially proposed, the format included a three-phased approach.

Phase I - A five-month teaching program
Phase II - An "internship" inside Afghanistan
Phase III - A three-month advanced subject teaching program

Two groups completed Phase I of this divided approach; however, difficulties or inability of students to return for Phase III resulted in a reevaluation of the system and subsequent combination of Phase I and Phase III preceding students' return "inside". Current classes are now offered an eight-month didactic and practical experience prior to assignment inside.

IMC has expanded the educational and clinical facilities at Nasir Bagh, thus providing both a teaching and community service function. These facilities continue to evolve and improve.

Relationships have been established with local health facilities to further enhance the educational opportunities and experience of the student medics. The Afghan Surgical Hospital is used for surgical observation and "rounds" teaching and some "guest lecturers" are used.

To date, 58 students in two class groups have completed the course (with the exception of Phase III) and 44 of these are currently working inside. One IMC medic has been killed. The third and current class of 32 will complete the new combined "8-month" approach prior to assignment. This group will have an accelerated course including evening sessions to allow for completion and assignment inside, at an earlier time frame (7 months total).

In general, IMC students are drawn from areas of Afghanistan not located in close proximity to the Pakistan border. In an attempt to provide health services to far distant regions of the country, training participants are selected largely from northern and central Afghanistan (Map C, Table 9).

To date, the applications for admission to all classes have far exceeded the number selected ensuring IMC of the ability to maintain their goals for each class related to numbers of students and standards of selection criteria. Some degree of flexibility is practiced within the selection standards to provide for geographical distribution and contingencies. Administrative decisions were made early in the program planning to develop materials and deliver the course content in Farsi, thus providing a clear focus for recruitment selection, translation capacity and materials development.

b. Facilities

(1) Teaching

The teaching facilities of IMC include two classrooms, a microbiology and parisitology laboratory classroom, a practical/dry lab and a goat lab area. In addition, the IMC clinics compound provides supervised patient practicals with a 1 to 2 ratio of instructors to students. The "main" house has been divided to include the lecture classrooms as well as the administrative areas, faculty housing and dining area. Some goat labs are also held in these rooms. Students' living quarters are located separately within the complex. While such proximity of classrooms and faculty may be advantageous in some respects, it is also significantly stressful for the faculty for space and privacy.

(2) Service

The IMC clinic is located separately from the main compound and services approximately 80 patients a day through four stations and a dispensary. Patients are drawn from the surrounding refugee population. A screening/triage system is utilized to determine the patients seen. Patients are apprised of the fact the clinic is a teaching facility. IMC teaching faculty provide supervision of students and primary medical services for the clinic. The ratio of instructor to students is 1 to 2 on a preplanned rotation basis. Translators are assigned in these areas as well as lecture and lab sessions.

Students in the clinic are said to demonstrate proficiency in each of the sections of the clinic prior to completion of the course. However, no specific documentation system of individual students' performance is recorded. Staff express confidence that most students are 70 to 80% accurate in demonstrating proficiency and "should" perform their duties at an acceptable standard of practice.

In addition to these service area experiences, students are also provided a range of surgical experiences through observations/rounds with their surgical instructor (male only) at the Afghan Surgical Hospital.

c. Course Admission Criteria and Retention System

The admission criteria and retention system is outlined in Table 10. To date, IMC's ability to select from a sufficient pool of applicants allows a degree of uniformity and maintenance of standards. The cooperative arrangement with the Swedish Committee is an excellent mechanism which provides both an alternative for "dropped" students and a beginning stratification system for health providers in the future. As additional experience is gained, this system could be further expanded to include a coordinated referral system for nonaccepted IMC admissions, as well as "dropped" students, thus maximizing on the advantage of IMC's pool of applicants and providing IMC data to monitor, analyze and refine selection criteria and curriculum focus for the future.

d. Curriculum and Methodology Content

The curriculum as established (Table 11) with refinement of level of detail and supplementation of nursing skills, currently planned by IMC is appropriate. Combined with improved teaching practices, students could be offered an ambitious but well-integrated learning experience. The balance of practice and theory in a cause, effect and treatment approach should reinforce knowledge and build skills.

The stated 70-80% standards for retention and completion is both appropriate and essential for the future practice of these medics and should be documented and verified to assure achievement. Once the curriculum content is "finalized", it should remain stable with instructor compliance to content.

Future curriculum changes should be initiated only after careful evaluation is undertaken (e.g., the case log books and potential inside monitoring information analysis could be used to change the curriculum on the basis of quality of care delivered, as well as quantity, or trends of illnesses/injuries being treated).

Some identification and planning should be considered to utilize exceptional and experienced graduates as part of the faculty for future classes. If and when this is accomplished, a careful approach to the additional educational needs of these "teachers" should be developed.

One area not currently taught is that of humanitarian principles and the obligations of medical workers. Although this may be touched upon in medical ethics sessions, a review of the content of this class should be made to determine if it should be specifically strengthened.

A group of consistent and skilled translators work under the direction of a highly qualified chief translator. They provide both oral and written Farsi translations, and these services are provided at all clinic stations, lectures and laboratory practicums.

Expatriate staff are specifically recruited and assigned by the home office to full-time schedules which accommodate the curriculum specialty areas. They receive briefings, lecture "guide" materials and an instruction packet. References, licensure, and background checks are made prior to selection. The current staff is enthusiastic and effective in both relationships with students and commitment to teaching. However, without a finalized curriculum base and numerous instructors with differing backgrounds, there is an inherent potential weakness in curriculum integrity within and between class groups.

While the course in total is excellent from a medical, theoretical and technical perspective, the conditions of practice would seem to warrant some additional curriculum material and practice in such areas as site selection, field water and sanitation systems and a greater emphasis on field transport methods for various injuries as well as longer term or follow-up care of patients.

Overall the educational program of IMC is to be applauded. The motivation, enthusiasm and comments of the students speak to their satisfaction and faculty members are individually and collectively impressed by the intense desire and degree of learning evident in this group of students.

Methodologies

Lectures, demonstrations, and practical experiences are the basic formats used. While current charts, anatomical models and audio visuals (slides) are limited but adequate, some additional attention to teaching devices such as flannel boards could improve the quality of lecture material and enhance the limited blackboard visual information. The size of anatomical charts should be increased for student visibility during lectures. A system of monitoring the mastery of specific skills should be developed to track each student's demonstrated proficiency or deficiency areas. (Identify each specific skill and provide individual student checklists.) In view of the changing faculty such a system would also allow new faculty members to know which skills were still deficient.

One final note, while the importance of preventative health is taught, the curriculum is heavily therapeutic in content and as students overwhelmingly prefer these areas, a preventative health focus should continue to be stressed throughout the course by all faculty and its importance emphasized by the faculty role models. Graduates should demonstrate proficiency in teaching prevention as well as delivery of therapeutic services.

Student materials would be greatly enhanced by simplified "How to" procedures as well as "What to do" management, including simple standard protocols. Graphics could be greatly improved, as should the quality of the reproduction materials--(unreadable). The current format of the four manuals is acceptable for notes and study during specific course lectures, but is very cumbersome and fragmented for an operation or for use in the field as a reference manual (four manuals plus lab manual and pharmacology manual).

e. Educational Administration and Faculty

IMC's current teaching staff are motivated, enthusiastic and knowledgeable health professionals with various specialty areas/skills. An expatriate medical director oversees management of the field:

scheduling of instructors, clinic staff, appropriate curriculum delivery, clinic supervision and student educational objectives. Expatriate instructors serve variable lengths of time with three months or less the average duration of the expatriate staff, including several of the previous medical directors. Continuity for the students is provided by a permanent Afghan surgeon and Afghan Microbiology/Laboratory instructor. All faculty express the need for curriculum strengthening in nursing skill areas, simplification and refinement of all subject areas to the essential material to be covered thus providing greater uniformity of future lectures and quality learning of essential information/ discussion. The rotations, diversity of backgrounds and teaching expertise of multiple faculty members per class warrants greater curriculum adherence to assure students of each class the same quality and quantity of information.

Some attention to the teaching principles and teaching skills of all instructors should be provided by the home office and reinforced in the field. Heavy reliance on blackboards, student note taking and translators in lecture sessions requires consistent use of terminology and clear, concise blackboard notes which can be easily and correctly viewed and transcribed by students. Such consistency of teaching practice is essential for the rote memorization of medical terms and facts which is the practice of these students.

The continuity of a long-term/more permanent medical director to oversee curriculum and educational issues is much to be desired. Such consistency should be sought for the duration of each complete course at the minimum. IMC is currently moving to assign such an individual prior to the start of the of the next group of students (September).

f. Educational Program Recommendations

1) Identify, develop, implement and maintain a specific skills list to monitor individual student performance, completion and level of achievement.

2) Identify and develop/strengthen specific curriculum areas related to:

-- Nursing skills and follow-up patient care;
-- Preventive health measures and patient teaching;
-- Field management/problems; i.e., site selection/protection, water, sanitation and transport).

3) Complete and standardize curriculum content. Develop decision-making mechanisms for future changes (i.e., small curriculum committee to review/analyze information, ideas, need and impact on total program).

4) Complete/develop student materials with attention to design, format, and reproduction quality for dual study and field reference use.

5) Further enhance teaching tools and methods; i.e., oversized anatomical systems charts, flannel boards, models, or demonstration/practice procedure "doll".

6) Strengthen instructor selection and assignment system to include evaluation of teaching skills pre- and post-assignment, and formalize a uniform field performance evaluation procedure for all instructors.

7) Develop/strengthen strategies to recruit and develop additional Afghan professionals as future instructors to the maximum number possible.

8) Recruit and adhere to assignment of each medical director for a minimum one course assignment duration (length of one complete course).

9) Work with CMC for development of a unified core curriculum.

3. Monitoring and Evaluation

a. Overview

IMC has been very responsive to the AID/REP management data needs. All quarterly reports have been submitted on time and contained information requested. The quarterly reports clearly demonstrate IMC's close monitoring of the whereabouts of each of its students throughout their training in Peshawar and once they enter Afghanistan. Because of the large amount of statistics now being developed, IMC may want to consider placing this information in tabular form to facilitate the reader's ability to grasp a full picture of progress. The reports, while answering AID/REP requests for data, should also include analysis and interpretation of the data and how this information is used to solve problems.

b. Training

Following are examples of how IMC used its data to better the training program.

IMC has changed its curriculum from a three-phased to a two-phased program based on information collected by the Afghan field director.

An analysis performed on student's "Green" books (patient log books) revealed that the greatest need in many areas of Afghanistan was for public health[13]. As a result of this analysis, IMC has refocused its curriculum to include a greater emphasis in this area. Eventually the data will be used to revise the teaching manual.

13 Once the data is compiled from the student's "Green Books," it is sent to IMC/LA for analysis. Analyses, interpretation and application of such data needs input from staff directly involved in training and establishment of clinics rather than analyzed and interpreted by individuals so removed from the scene.

c. Clinics

IMC currently employs five Afghan monitors. The IMC monitors are responsible for taking the medics to their clinics, introducing the medic to the Malik and community and assessing the medics' performance. The monitor make their assessments by cross-checking information from resident population served and others outside the community. Given the broad range of responsibility of these monitors, five may be inadequate to establish and assess the number of clinics IMC has established.

Students are responsible for completing two types of patient log books: (1) the "Green" book is used for maintaining information on diseases treated by sex, age (for children) and if patient is a Mujahid or civilian; (2) the "Yellow" book is for maintaining information on the treatment of injuries: name of patient, age, sex, type of wound, location of wound, mechanism (cause) of wound, procedure performed, patient outcome and whether person is a Mujahid or civilian.

During interviews, IMC staff acknowledged that monitoring the performance of students once they are in their clinics is still a problem. Its Afghan monitors are not medically trained and are, therefore, not qualified to assess the extent to which their students are adequately skilled and knowledgeable to provide quality health services. While IMC has learned a lot from reviewing student books, the level of monitoring to date provides mostly information on "quantity" rather than "quality. IMC has recognized the need for medical assessment and is working with other groups to evaluate its medics inside.

IMC's Afghan surgeon has been responsible for reviewing the books that have been returned. Analysis of this data in LA will reveal the prevalence of different diseases in different areas in Afghanistan and IMC intends to use the findings to guide resupplies of medicines and medical supplies.

d. Staff Evaluation

IMC recruitment procedures include several interviews by phone, or when possible, interviews in person and reference checks to verify information provided in resumes.

Once in Peshawar, IMC/LA monitors staff effectiveness through bi-monthly phone calls with IMC/Peshawar and modem link between IMC/LA and Peshawar. The Administrative Director in Peshawar informally reports on staff capability to IMC/LA by phone calls, minutes of meetings and quarterly reports. The Administrative Director does not, however, write formal evaluations of staff. According to this Administrative Director, IMC/LA monitors his effectiveness by reviewing how he handles the budget, how well he deals with conflicts and through impressions of other staff.

The Medical Director in IMC/Peshawar monitors teaching effectiveness and appropriateness through various methods. The entire medical staff live together and the director has an opportunity to get to know staff on a personal level. The director requests each instructor to provide a course outline for review. He also reviews course questions that are developed weekly by each instructor. Finally, he sits in on several classes and directly observes what and how they teach. Based on these informal methods of assessment, he provides the instructor any needed feedback. Instructors that are unsatisfactory are asked to leave.

e. Recommendations

1) IMC should develop an overall written plan for M&E. This plan should include current as well as future data needs and methods for collecting student performance data during training and inside Afghanistan. The plan should be specific with adequate detail for guiding implementation. It should be management-oriented, user-driven and geared toward the "minimum necessary".

2) Analysis and interpretation of data should be performed in IMC/Peshawar with input from Afghan staff. Conclusions drawn from analysis should be utilized for decision-making related to planned changes in pertinent areas (i.e., curriculum, inside operations, etc.).

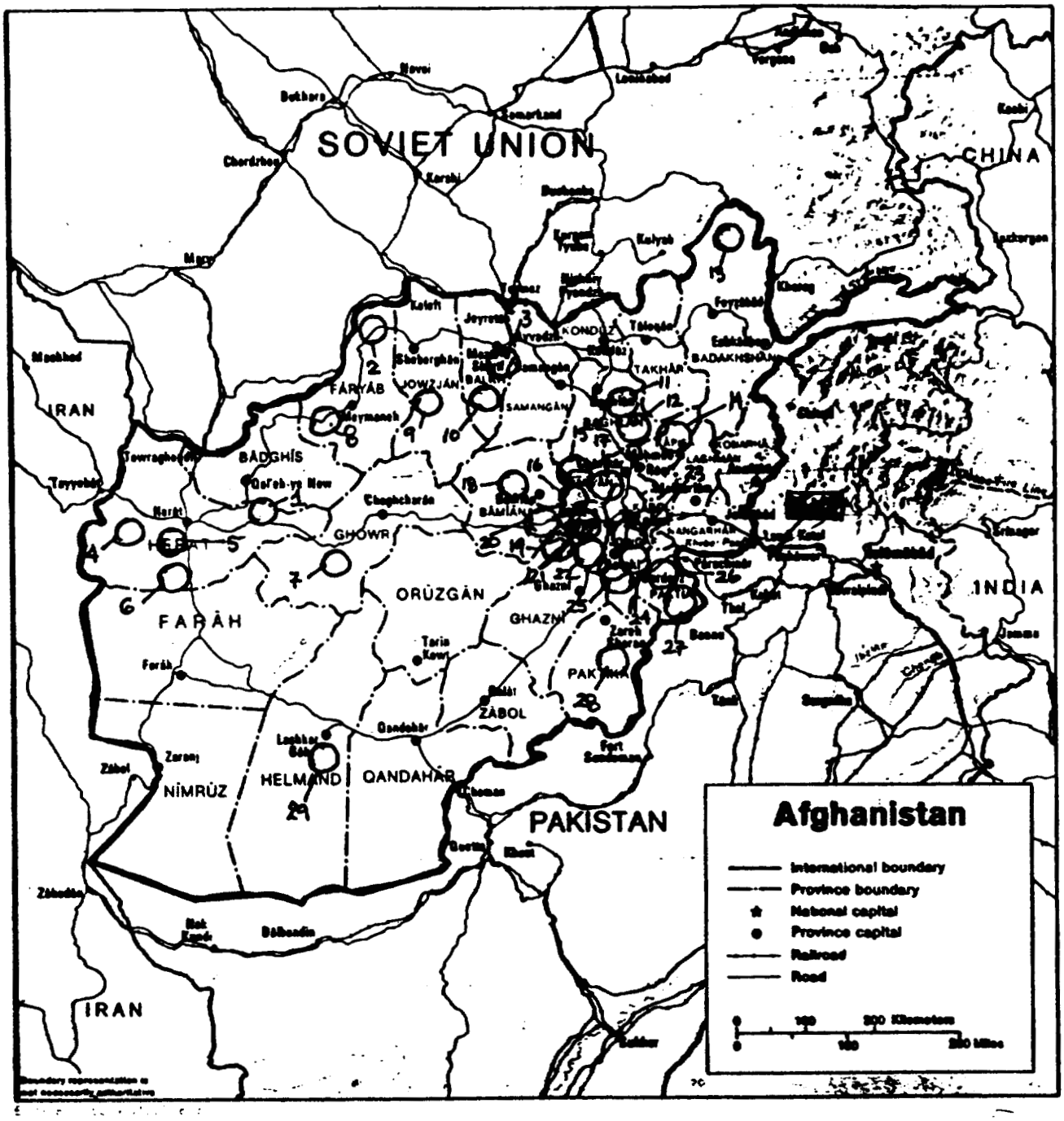
3) In conjunction with CMC, IMC should conduct medical assessments of its clinics inside Afghanistan on an annual basis. ICM should make every effort to coordinate with CMC to accomplish review of clinics to identify gaps and excesses in its curriculum and assist students with any areas of difficulty.

4) Data collected should be reviewed annually to determine utility for problem-solving and decision-making. Data that has not proven useful should be discarded to assure "minimum necessary". This annual review would be an opportunity for substituting more useful indicators as well as deleting. Data collection instruments should also be reviewed at this time and incorporated in appropriate systems (i.e., training, management, etc.).

5) Following each quarterly report, the entire IMC field staff should meet to review findings and develop a coordinated home office and field plan of action for addressing problem areas.

6) Quarterly reports should reflect objectives to have been achieved and progress to date with tabular data comparison. Analysis/interpretation of data should be included as well as identification of problems and solutions. More information should be provided on the functioning of clinics inside.

MAP C: HEALTH FACILITIES OF INTERNATIONAL MEDICAL CORPS (IMC)
IN AFGHANISTAN
(July 1987)



*Numbers refer to Table

[redacted]

TABLE 9

HEALTH FACILITIES IN AFGHANISTAN
IMC - INTERNATIONAL MEDICAL CORPS

(See Map)

As of July 1987

29 fixed units - - - - - - 3 hospitals - - - - - - - - - 26 clinics

Province	Village/Town	Party Affiliation
HOSPITAL:		
1. Herat	Obeh	Jamiat
2. Faryab	Andkhoi	Jamiat
3. Balkh	Charkent	Harakat
CLINICS:		
4. Herat	Ghurian	Jamiat
5. Herat	Herat City	Mahaz (Gailani)
6. Herat	Gurhan	Jamiat
7. Ghor	Pasawand	Herb
8. Faryab	Almar	Harakat
9. Jorzan	Sar-i-Pul	Jamiat
10. Balkh	Keshendeh-Payeen	Harakat
11. Baghlan	Narin	Jamiat
12. Baghlan	Ghorband	Jamiat
13. Badakhshan	Darwoz	Jamiat
14. Kapisa	Panjshir	Jamiat (Masood)
15. Parwan		-
16. Parwan		-
17. Parwan	Ko-i-stan	Herb
18. Bamiyan	Sim Sarah	Jamiat
19. Wardak	Schneez	Herb
20. Wardak	Maidan	Harakat
21. Wardak	Tangi	Harakat
22. Wardak	Jaghatu	Mohaz
23. Kabul	Paghman	Herb
24. Logar	Sorkh Ab	Herb
25. Logar	Baraki	Harakat
26. Paktia	Syed Karam	Harakat
27. Paktia	Khost	Harakat, Herb, Mahaz & LKF
28. Paktika	Urgun	Harakat
29. Helmand	Nawah	Jamiat

[redacted]

TABLE 10

International Medical Corps
Admission and Retention Criteria

Eight-Month Medic Course

Recruitment:	Commanders' recommendation and Alliance approval
Criteria:	Formal Application
Admission:	Farsi Speaking Tenth grade/equivalent minimum education requirement Entrance examination and interview Non-migration of immediate family menbers Good health Prefer 25-year age bracket Flexibility of criteria to meet geographical need/considerations
Retention:	Class examination weekly with instructor conferences regarding progress. Instructors submit outlines and list of questions for exam. Final examination at conclusion of course covering all subjects 80 percent pass grade but some flexibility for geographical areas of need or contingencies Deficient grades/unsatisfactory performance result in counseling out of program with referral to Swedish Committee. This Committee tests dropped IMC students for possible acceptance as a "lower-level" health worker within their system.
Current Instructors	* Expatriate instructors assigned for varying time durations and specialty areas of in struction during the course includes physicians, nurses, and paramedics. * Two Afghan professionals fill permanent faculty roles -- one surgeon and one microbiologist/laboratory specialist. * Current medical director leaving early due to injury. Replacement staff due "shortly"

TABLE 11

IMC - INTERNATIONAL MEDICAL CORP.
Course Structure - Certification and Assignment Specifics
page 2

IMC Medics Course - 8 Months (cont'd)

Ob/Gyn	9	Lecture 9*	"	"	"
Surgery (include methods of patient transport and anesthesia)	Approx 140	Lab.- Intersperced lecture with lab	"	"	"
Phase III-Advanced Subj. (neurology, endocrinology, hematology, parasitology plus chest tubes, amputations & gas gangrene.	45	Lecture/Lab 30* /15*	"	"	"

- Daily 6* supervised practicum in clinic.

* - hour
- Certificate of Completion and Assignment:

  -- Certificate presented at graduation.

  -- No distinction made for outstanding students. However, may make assignments inside for independent practice for honor students ("own clinics").

  -- Usually students assigned 2-3 together in some area/province.

  -- Monitors accompany graduates and equipment to assigned area and provide introductions to the community.

- Pay Scale Graduates:

  -- 2,000 Rps/month when assigned to own province/home area.

  -- 2,500 Rps/month when assigned outside home province.

  -- Paid five months in advance when go inside with start up supplies.

TABLE 11

IMC - INTERNATIONAL MEDICAL CORP.
Course Structure - Certification and Assignment Specifics
(1 of 3 Pages)

IMC Medics Course - 8 Months

Subject Area	Approx. Hours of Instruction	Methodology	Student Materials
Microbiology/Parasitology	39	Lecture/Lab 15° /24°	IMC Developed Reference.
Pharmacology	36	Lecture/Lab 30° / 6°	Texts-Translated Farsi.
History/Physical Exam	24	Lecture/Lab 6° /18°	(Series of 4-Lab Manual and Drug Manual).
Basic Anatomy/Physiology	24	Lecture/Lab 12° /12°	Slides.
Skin Diseases	12	Lecture 12°	Limited Size & number of charts & anatomy models.
Respiratory Diseases	12	Lecture/Lab 9° / 3°	Micro-Lab & Goat Lab used throughout course.
Cardiovascular Diseases	12	Lecture/Lab 9° / 3°	" " "
Gastroenterology	12	Lecture/Lab 9° / 3°	" " "
Eye	9	Lecture/Lab 6° / 3°	" " "
ENT/Dental	12	Lecture/Lab 9° / 3°	" " "
Genitourinary	24	Lecture/Lab 18° / 6°	" " "
Musculoskeletal	15	Lecture 15°	" " "
Orthopedics	21	Lecture/Lab 9° /12°	" " "
Endocrine	6	Lecture 6°	" " "
Neurology	3	Lecture 3°	" " "
Miscellaneous Subjects (Bites, burns, frost-bite, shock, malaria, heat)	18	Lecture 18°	" " "
Pediatrics/Immunizations	12	Lecture 12°	" " "

TABLE 11

International Medical Corps

IMC - Certification and Assignment Specifics
(Pg 3 of 3 Pgs)

Certificate of Completion:	* Certificate presented at graduation * No distinction made for outstanding students. However, may make assignments inside for independent practice for honor students ("own clinics") * Usually students assigned 2-3 together in same area/province. * Monitors accompany graduates and equipment to assigned area and provide introductions to the community.
Pay Scale	* RS 2000/month when assigned to own province/home area
Graduates:	* Rs 2500/month when assigned outside home province * Paid five months in advance when go inside with start-up supplies.
Assignments:	* Assigned to designated A-B-C-D facilities which are differentiated by function, equipment, and staffing, in addition to graduates.

A=Hospital - fixed facility with physician (Afghan)

B=Clinic - Fixed/mobile with nurse on site Limited surgical services. Community health service focus.

C=Clinic - semi-mobile. Limited surgical services. "Graduates" staff.

D=Clinics - mostly mobile in insecure areas, limited both in medical and surgical services. Primary focus immediate emergency care and stabilization. "Graduates" staff.

Initial Supply: Six months.

Resupply: By request

C. Freedom Medicine (FM)

1. Introduction to FM

a. Location, General Objectives

Founded in 1983 and incorporated in 1985 to assist disaster-stricken areas, Freedom Medicine is a PVO whose activities focus only upon Afghanistan. With its present home office in Honolulu, Hawaii, FM has been in operation for approximately one and one-half years. Its major goal is to train "quality health care medics" in a short period of time and to subsequently sustain and monitor their work inside Afghanistan.

To accomplish this, FM has established an administrative office in Peshawar and a training center/surgical hospital/OPD ("Fort Freedom") in Thal, a refugee-filled area of the NWFP which is approximately 150 km southwest of Peshawar. In addition, FM has two paramedic stations near the border and a small clinic in Chitral (Map D, Page 86).

Freedom Medicine's six-month medic training began in February 1986 and, to date, two classes have graduated; at present approximately 19 students have returned to work inside Afghanistan. Table 12 contains data about these returnees and Map D illustrates their home locations. Most medics are from central and northern regions of the country.

b. Organizational Structure and Function

(1) The FM Office In Pakistan

Freedom Medicine sustains five separate facilities throughout the NWFP and has a large and growing professional and support staff. Presently there are seven expatriate technical staff in Thal (three doctors, three nurses and one paramedic), along with an excellent group of five newly-hired Afghan physicians, a team of five Afghan translators and a large support staff. To date the founders of FM, a husband and wife team, have been filling the positions of Project Director and Field Director.

As time has passed, the FM directors have been hard-pressed to keep up with a rapidly-expanding project and have not delegated authority to other staff members. This problem, in part, has been recognized and in its new grant proposal FM provided job descriptions and requested funding for the following newly-created positions: camp manager, hospital supervisor, training coordinator and medical director.

Experienced individuals have been recruited for camp manager and training coordinator, and they expect to arrive in Pakistan in a few months. However until the co-directors actually delegate authority the problem of administration will not be resolved.

Turnover in technical staff has been a problem. With expatriates often able to stay for only a few months, continuity in training was lacking. In order to address this problem, Freedom Medicine recruited and has hired Afghan medical personnel.

The Afghan staff is highly-qualified and relations between expatriates and Afghans are extremely positive. A number of the expatriate staff, including the Project Director, have learned basic Farsi in a short period of time and they are extremely dedicated. A definitely positive esprit de corps is present at the training facility at Thal.

(2) Relations Between Home Office and Field

With the founders of FM on the field staff, FM's decision-making authority lies in Peshawar and not with the Executive Director in Hawaii and its small Board of Directors. Recruiting and fund-raising are largely the tasks of the home office.

The Project Director is contemplating moving the home office from Hawaii to New Jersey and hiring a new Executive Director (the previous individual is leaving for family reasons). Communications with Hawaii are difficult and a mainland office is thus preferred.

(3) Coordination with Afghans in Pakistan and Afghanistan

(a) Afghan Parties, Commanders and IMC

Similar to other PVOs, commanders propose students for FM's medic courses. As can be seen from Table 12, the parties represented among graduate returnees are indeed varied: Mahaz, Harakat, Hezbi (Branch indefinite), Etehad, Jamiat and even Shora-i-Itifaq (a part of Shia/Hazara affiliation).

(b) General Framework for Service Delivery in Afghanistan

As shown on Map D, FM's 19 graduates who are said to be working in Afghanistan are scattered throughout 11 provinces in central and northern Afghanistan. In speaking with the Project Director, it was not clear whether the graduates were returning to existing or new facilities. The Afghan Special Projects Director was unfortunately unavailable for discussion due to illness, and it appeared that the Project Director lacked specific information about her graduates. It was also mentioned that there are a few monitors (two previous translators and two mujahiddin) who are employed to go to Afghanistan and check on graduates' activities. All of them were still in Afghanistan at the time of our field work.

The Swedish Committee furnishes departing graduates with medical supplies for 6 months. They are paid 1500 Rs salary per month and they are usually resupplied with medicines, etc., through their commanders or their representatives.

(4) Coordination Between FM Activities in Pakistan and Afghanistan

As described below, FM's training activities are exceptionally practical and attempt to creatively approximate settings to be later experienced by medics working inside Afghanistan. This appears to be due more to the general paramedic orientation of FM expatriate staff rather than specific feedback on what students require once they are back inside Afghanistan.

Data collection activity on facilities inside--(e.g., five clinic records, expended medicines, etc.)--and its transferral to FM in Pakistan remains an unclear area; it appears that in many ways this system has yet to be established. The newly-created post of Medical Director includes as one of the major tasks the analysis of the data flow from Afghanistan.

Conversations with the Project Director probably reflect both a lack of some knowledge on her part and an attempt to not disclose too many details of the FM system.

c. Coordination with Other PVOs, CMC and AID/Rep

From its initial grant proposal, one of FM's basic objectives has been to foster coordination between PVOs. Along with MTA and SCA, FM has established a training clinic in Chitral. In addition, FM students are sent to MRCA for additional training in dentistry, physiotherapy, etc. This additional training is undertaken especially by those students who have graduated and who must wait a few months to enter Afghanistan due to the winter season. Outside evaluation of FM graduates in Pakistan is also done by the Swedish Committee and MSF. However, FM has not been enthusiastic about the evaluation of its returned graduates by an AMI mission soon to be undertaken; it appears that it does not agree with how the team has arranged for this field evaluation inside Afghanistan.

In the CMC, FM's Project Director is an active member and she has served this past year as co-chairperson. Indeed, she was instrumental in its formation and now shares a portion of the FM Peshawar Office with the CMC itself.

Timely reporting to AID/REP has not been achieved by FM, with sometimes nine months elapsing between submitted reports. It appears that the staff has had other priorities concerning the day-to-day functioning of the project, has been short of administrative staff and has been severely overworked. Hopefully, with the arrival of additional staff members and some reorganization, the situation will improve.

d. Recommendations

1) The general administration of FM must be improved. Job descriptions must be written and authority must be delegated to the new staff members (camp manager, hospital supervisor, training coordinator, medical director, etc.) when they arrive.

2) Efforts should be made to recruit expatriate technical staff for longer periods than just a few months. The move of the home office from Hawaii to the mainland and a change in the Executive Director may facilitate this.

3) FM must obtain information about its graduates and their activities inside Afghanistan. In order to improve/perfect its program and coordination among PVOs, FM should become more candid about its cross-border functioning.

2. Educational Component of Freedom Medicine Program/Project

a. Background

Freedom Medicine began the Afghan Paramedic Health Workers program in 1985. It is currently training a third class (18 students). The course duration is six (6) months and to-date there are 31 graduates. Thirteen are operating within Afghanistan and 16 are awaiting medicines, supplies and transport. During this delay, several have taken the opportunity to complete additional advanced training in dental/surgical areas with another cooperating PVO. Others continue to gain experience at Freedom Medicine Clinic/Hospital.

In addition to the training courses, the upgrading and improvement of FM facilities has also been achieved using the services of Afghan refugee craftsmen and laborers from the surrounding area. Development of the curriculum, educational and operational administrative structures and pertinent external relationships continue to evolve. During this formative period, students of the first group also conducted a short-lived "strike". Following discussions, all issues were resolved and further incidences have not occurred. In addition to the six-month paramedic course, a basic first-aid course taught by six-month students to other mujahiddin has been incorporated as part of the overall instruction process.

b. Facilities

(1) Teaching

All structures and facilities of Freedom Medicine have undergone considerable development and improvement since the initiation of the

project. Two permanent classrooms and a faculty training office are part of this expansion. The classrooms, while under cover, are currently part of a brick structure enclosed on three of the four sides. Students sit on mat/rug covered floors. No chairs/desks are provided. Blackboards and graphics/charts are used by instructors to present lecture materials. Farsi-speaking translators are scheduled for expatriate instructors. The absence of chairs/desks reinforces the circumstance of future assignment conditions but provides a degree of difficulty for student note taking. The recent installation of a fan provides a degree of environmental comfort for instructors and students and heaters are used in the winter months.

The hospital, emergency room, laboratory and dispensary areas are co-located separate from the training compound. They have all recently been built/improved and provide facilities for practical teaching experiences.

(2) Service

The clinic (OPD) is very basic and fundamental in construction and concept. Patients, who come from the surrounding refugee community, are screened/triaged each day based on need for care as well as types of illness for student learning opportunities. Afghan and expatriate staff provide both service and student instruction with an approximate two to six ratio. A 24-hour, on-call team of physician, nurse and two students provides both service and teaching experience for the emergency room services. The 30-bed hospital contains a separate women's ward and surgical "suite". An Afghan surgeon provides coverage and supervision for these areas. A hospital charge nurse is being sought to provide administrative direction as well as education upgrade and supervision of Afghan nursing and support personnel. While the caseload of the clinic continues to be significant (approximately 1200-1500/month), the hospital occupancy, emergency room and surgical services are minimal at present. As these facilities have very recently opened, the eventual degree of use by the community/inside patients cannot be determined at this time. However, a few surgical cases involving wounds of the chest/extremities were currently under treatment with students involved in these experiences.

The location of Freedom Medicine on a major road exchange provides opportunity for the local use of the facilities as well as war-wounded/referral admissions and transfers. The coverage of these service facilities by the Afghan and expatriate professionals assures the maintenance of reasonable quality standards in both service delivery and educational experiences.

c. Course Admission, Retention and Criteria Systems

The admission and retention system is outlined in Table 13. To date, Freedom Medicine has achieved the ability to recruit and select from a sufficient pool of applicants to accommodate both class size and a degree of uniformity of admission standards.

FM has 18 students in the current (third) class; one is repeating the course due to poor performance in the prior class.

The retention rate of students has remained very high--80-90%. Written examinations are administered monthly and practical skills evaluated through extensive field/classroom exercises and follow-up critiques by instructors.

An oral "Board" exam is given at the end of three months. With each student responding to a scenario presented by a three-person instructor panel.

Between the previous classes the performance percent of students has been consistently within similar ranges--(four to five students at the top (A-B grade) and four to five at the lower pass range (C-D). The (10-12) remainder are in the average (C-B) range).

In general, the retention requirements of students are mainly weighed on their ability to demonstrate practical proficiency, and their logic/decision-making ability to deal with realistic situations they may encounter in the field.

d. Curriculum and Methodology

The current curriculum of Freedom Medicine is the result of a continuous evolution over the past two courses. The result is a new, nearly completed syllabus. It includes well-defined content at a consistent theoretical level throughout each section. The format is simple, directive, and well integrated. Heavy emphasis on practical application and attention to essential knowledge and skill base provides a focus for rotating instructors and allows students the time to learn and apply essential information. Completion of the "final" product and quality translation will make this new draft syllabus a useful study guide and reference for students. When implemented, it should be adhered to by future instructors and revisions/refinements made, based on careful analysis of new information, identified need, and total course impact. Stabilization of the curriculum, lesson plans and instructor presentations should now be encouraged. FM should consider establishing a small curriculum committee to carefully address decisions on future changes in a planned, rather than ad hoc, manner. The current course structure in outlined in Table 14.

Much of the strength of FM's current curriculum is directly due to the careful attention to the development of each content lesson, the level of information and the integration of practical application. When completed and fully implemented, FM students will be afforded a well-integrated and practical education offering consistent with both their future practice environment and expected level of performance.

The balance of methodologies used (lectures, goat labs, practical labs and field exercises) allows optimal integration of theory and practice. Students would further benefit from the addition of composited reference material in addition to notes and handouts.

The presentations by several Afghan instructors and services of good translators has further enhanced the learning opportunity of these students as little time is wasted from lack of language comprehension.

The rotation of students through the OPD, Hospital, Emergency Call/Ambulance, Camp Teaching and Chitral Clinic provides a diverse practical experience intended to build confidence and skills in a variety of settings. Each student's experience in some of these areas is somewhat dependent on the actual number or type of cases seen during individual rotation experiences. However, well-planned extensive field exercises compliment these rotations and minimize potential clinical deficiencies.

The identification, development and implementation of a specific skills list system would greatly enhance the ability of instructors to evaluate and track the demonstrated proficiency of individual student's specific skills needing correction or additional instructional attention. Such individual tracking systems become even more essential in view of FM's plans to have overlapping classes (groups) in the future. The overlapping of classes will improve the cost-effectiveness of the program and the number of students "produced" by FM. With the current instructor complement, this would appear to be an achievable goal. Pre-planning, careful scheduling and subsystems must be maintained to avoid both "burn-out" of instructors and a decrease in quality of instruction. The stabilization, "finalization" and adherence to curriculum content will be a significant component for success in such an endeavor.

Overall, FM appears to have a good educational program. The potential weakness lies in the lack of follow-up information of student activities and performance inside Afghanistan. Curriculum emphasis and the appropriate development of needed student skills or theory are predicated upon feedback and analysis of such data.

e. Educational Administration and Faculty

Instructors are scheduled by a training coordinator system. Currently, this position is filled by an "acting" coordinator, pending the recruitment/assignment of a permanent expatriate. The system provides excellent coordination of instructor and translator resources for the numerous student classroom and practical activities as well as logistics planning. The need for this full-time, non-teaching position will become even more critical with dual groups of students.

The recruitment of expatriate personnel and support by the "home office" is somewhat deficient in both system and effectiveness. A rather ad hoc approach seems to exist between the field and Hawaii with a loose telephone interview being the basis for appointment. A more defined, systematic process of procedures is warranted to assure both quality, quantity and specific type of instructional personnel being recruited, screened and assigned in a pre-planned time frame. Such a personnel process should also include specific standard orientation procedures pre- and post-arrival in the field.

Overall administrative roles have, in the past, not been delegated sufficiently to accommodate the growing scope of responsibilities. Clearly identified roles and authorities need to be established not only for the education component but the overall organization. FM is currently attempting to establish a more decentralized organization. The filling of new positions and implementation of expanded leadership team approach is essential for future growth and coordination of all the project components.

f. Educational Program Recommendation

1) Develop job descriptions which clearly specify roles, responsibilities and authorities.

2) Finalize and implement curriculum as designed, including student reference materials.

3) Establish mechanism for planned revision of curriculum for future, based on analysis of need and program impact (e.g., a curriculm committee).

4) Develop and implement uniform comprehensive expatriate personnel system and procedures.

5) Develop cooperative arrangements to obtain needed inside evaluation information.

6) Identify, develop, implement and maintain a skills list system to monitor individual student performance, completion and level of achievement.

7) Establish plan for "layover" students awaiting assignment inside. (Alternatives for solution such as: other education courses, experiences or paid work assignments).

3. Monitoring and Evaluation

a. Overview

The proposal language of FM, related to program monitoring and evaluation, is ambitious and takes the form of formative and impact evaluations, as stated:

"Program monitoring will be done to insure that the project is being implemented as designed or that there is appropriate participation in decisions about major changes in project emphasis. Project monitoring by Freedom Medicine's administrative field staff and the Board of Directors will take the form of periodic meetings and communication between the administrative field staff and the Board of Directors to review project activities and budgets. The monitoring will provide the opportunity for self-assessment to correct deficiencies and highlight successes of the project. In addition, it will insure accountability to funding sources.

A formative evaluation will be undertaken to identify possible project refinements or adjustments. This evaluation will be conducted from 12-18 months after the formal start of the project. This evaluation will be organized around several questions including:

What are the project's original goals?
Are these goals still valid?
What are the project's current objectives?
Are those objectives being achieved?
What aspects of the project need to be refined or terminated?
What major problems or challenges does the project confront?

In addition to the formative evaluation, Freedom Medicine will involve itself in the assessment of the impacts of its activities on the care for the sick and wounded in Afghanistan and the refugee camps in Pakistan. The basic purpose of this effort is to trace the interactive affects of Freedom Medicine's activities on both the practice and impact of medical health care delivery in Afghanistan and Pakistan."

Data received in reports has not been reflective of the proposed plan.

Reporting by FM has neither been timely nor substantive. Reports when received are colorfully descriptive, however, they are lacking in analytical and statistical assessment of performance related to target objectives for the specific reporting period.

Very limited evidence exists related to monitoring or evaluation of graduates of the program assigned within Afghanistan. Knowledge by FM of their actual whereabouts is sketchy, questionable or closely guarded.

Modifications to program systems, administrative structure, delegation of roles, data collection, etc., and decision-making appears to be intuitive or informal rather than a coordinated planned approach based on analysis and impact.

b. Training

Freedom Medicine has demonstrated a degree of success in utilizing informally-collected information for decision-making purposes related to education.

Examples include:

1. Throughout the first training class, FM teachers were amending/changing the curriculum detailed in the Special Forces manual.

Amendments: simplify language and level of information
discard things that were not essential

Current curriculum, while not finalized is more appropriate and theory and practice well integrated.

2. Ad hoc evaluation of the students by outside experts. Results: Students provided very limited feedback--not really helpful. However, the trainees knew themselves that they needed better materials and curriculum.

Amendments: Instructors began putting revised curriculum together themselves.

3. Students were tested every month on classroom information and skills testing accomplished by practical exercises--1 big field practical; lots of small practicals. Strengths revealed of first class were in areas/skills of emergency medicine. Weakest areas were diagnosis of disease. The next training team included a person who knew public health well.

Amendments: Weakness of the second group of students reflected staff interest in public health. Second class was weak in emergency medicine.

4. A decision was made regarding student performance and assignment in field. Depending on how students do/learn during training, the type/level, supplies/medicines received for inside assignments are now adjusted.

5. Instructors wanted to give students more experience and unsupervised work, so decisions were made to rotate them to Chitral to build confidence. Staff feels, based on watching them deal with patients, that they saw them build their confidence to perform independent of instructors.

Freedom Medicine should develop an organizational structure to accumulate, evaluate and make decisions on future curriculum issues in a coordinated preplanned way.

c. Clinics

The Freedom Medicine proposal states that: "Linkages, financial resources and logistical support by Freedom Medicine administrative staff will assure that students are regularly supplied with medicines and equipment. Follow-up evaluations of student performance by foreign medical personnel will provide the basis for student and program evaluation and supply monitoring."

The data related to student performance/activities are primarily patient log books which are given to MRCA for tabulation. (Some evaluation of quantity and types of cases can be determined. However, information on qualitative care or student strength or weakness is minimal.) There is not at this time adequate feedback from data analysis by MRCA nor from an inside medical assessment of student performance.

Freedom Medicine does not appear to monitor the supply or resupply of students, the logistic linkages or support of students assigned inside. Very little information or data is available to or from FM related to specifics of its inside graduates. Consequently, information gaps limit ability of FM to monitor, evaluate, modify or adapt program subsystems in a coordinated planned manner.

d. Staff Evaluation

Informal and peer evaluation of staff occurs through staff meetings/ discussions within FM complex which provides opportunity for discussions, ad hoc group meetings and problem resolution. Formal staff evaluation systems are not developed. A retrospective critique by all faculty and administration following the conclusion of the first and second courses provided information on which decisions were made for subsequent courses. However, the information from the critiques has not been recorded for report/future instructor background information.

These discussions have resulted in significant decision-making related to curriculum changes, categories of staff recruited as instructors and, more recently, proposed changes in the education administrative structure. Freedom Medicine should develop written format for obtaining and retaining these observations, recommendations and conclusions.

e. Recommendations

1) Develop an overall written strategy for monitoring and evaluation.

Specific data needs and systems for collection should be established for all current and future activities. The plan should be specific with adequate detail for guiding implementation. Data should be management oriented and user driven. It should be geared toward the minimum necessary rather than the maximum/global approach.

2) Develop a checklist to assess student work in Afghanistan.

During interviews with the administrative director, several ad hoc assessments of its students were cited. In each example cited, there was no identification of strengths or weaknesses, only whether or not the student was good. Such feedback is very limited for assisting in the improvement of its project.

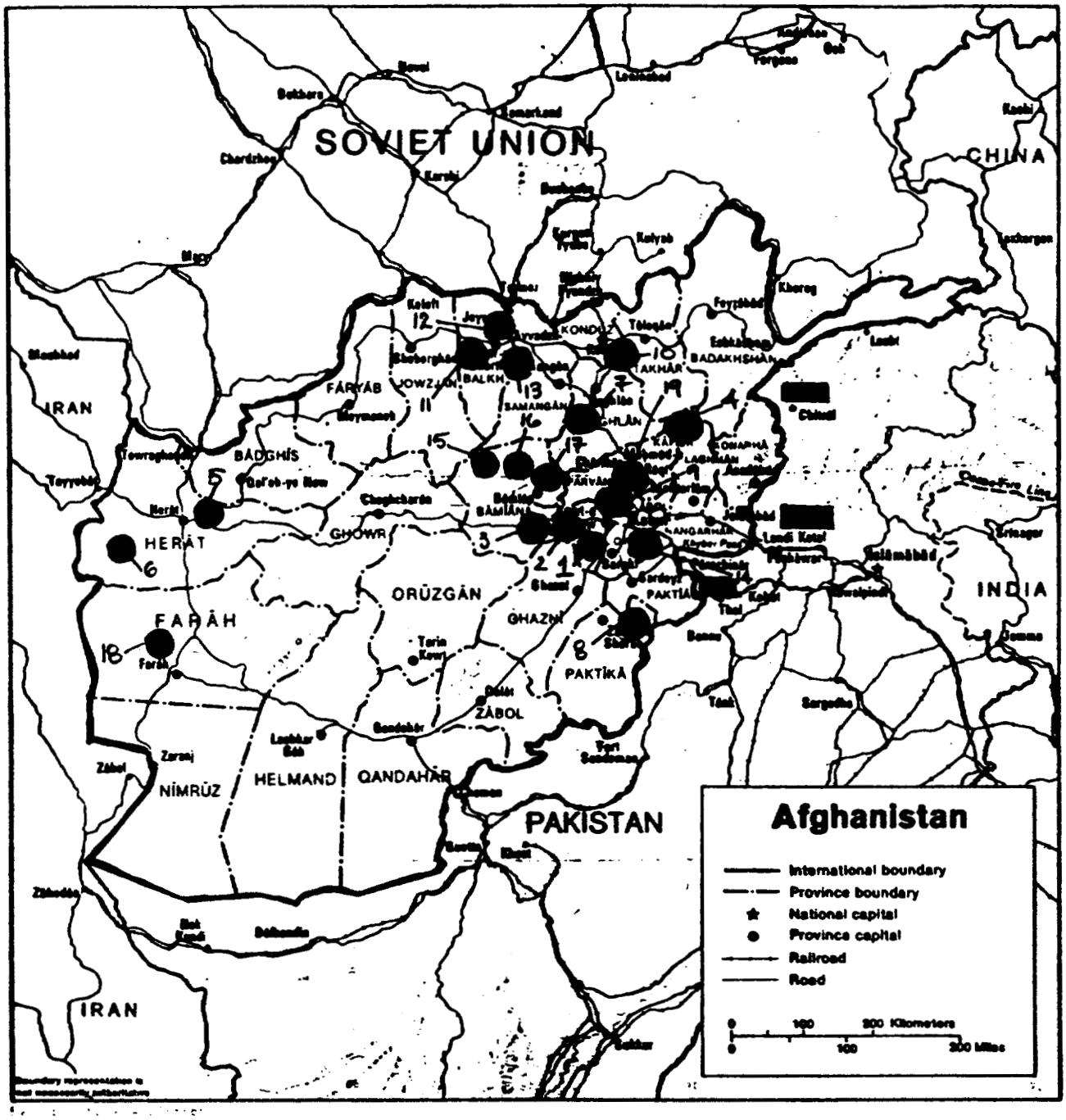
3) In conjuction with CMC, FM should conduct medical assessments of the performance of its graduates inside Afghanistan on an annual basis. At a minimum FM should either send in one of its own non-American medical staff or contract with non-American personnel/organizations to review some of the graduates to identify gaps/excesses in curriculum and assist students with any areas of difficulties.

4) Data collected should be reviewed annually to determine utility for problem-solving and decision-making. This annual review would provide an opportunity for substituting or deleting data elements as well as revising collection instruments for the upcoming year.

5) FM should improve and submit timely substantive quarterly reports to AID/REP relating to specific objectives/targets to the specific degree of accomplishment and detailing both problems and action for the next quarter (developed by members of FM staff from all subsystems).

MAP D: APPROXIMATE LOCATIONS OF FREEDOM MEDICINE (FM) TRAINING COURSE GRADUATES IN AFGHANISTAN
(July 1987)

*NOTE: Exact locations and health facility types are indefinite.



*Numbers refer to Table

TABLE 12

GRADUATED STUDENTS NOW IN AFGHANISTAN
FM - FREEDOM MEDICINE

As of July 1987

PROVINCE	VILLAGE/TOWN	PARTY AFFILIATION
FIRST CLASS		
1. WARDAK	Jagatu	Mahaz (2 students)
2. WARDAK	Sayed Abad	Harakat (2 students) and Hezb (2 students)
3. WARDAK	-	Shora-i-Itifaq
4. KAPISA	Rokha	Jamiat
5. HERAT	-	Jamiat
6. HERAT	-	Jamiat
7. BAGHLAN	-	Jamiat/Hezb (2 students)
8. PAKTIKA	-	Etehad
9. KABUL	-	Harakat
10. KUNDUZ	-	Jamiat
SECOND CLASS		
11. BALKH	Baba Awas/Mazar Sharif	Etehad
12. BALKH	Harbuzkhol/Mazar Sharif	Jamiat
13. BALKH	Samangandion	Jamiat
14. LOGAR	Shumbul/Jermas/Gandas	Shora-i-Itifaq
16. BAMIYAN	Waras	Mahaz
17. BAMIYAN	Waras/Sorkh Joi	Shora-i-Itifaq
18. FARAH	Parjuman	Harakat
19. Kabul	Chardeh	Harakat

* Type of health facility and exact location indefinite.

[redacted]

Freedom Medicine Table 13

Admission and Retention Criteria:

Recruitment: Commander's recommendation and Alliance approval

Criteria

Admission:

- o Tenth grade/equivalent minimum education requirement (prefer 12th)
- o Non-immigration of immediate family members
- o Farsi speaking
- o Screening and interview by Selection Committee/ individual
- o Flexibility of criteria to meet geographical needs/ consideration

Retention:

- o Class examination every month
- o Oral examination at end of 3 months on prepared "scenario" before 3 instructors
- o Field exercises and practical "skill station" exercises.

LIMITED OFFICIAL USE

FREEDOM MEDICINE

Course Structure - Certification and Assignment Specifics

Course: Afghan Paramedics Course - 6 Months

**Subject Areas	**Approx. Hours of Instruction	Methodology	Instructor and Student Materials/Experiences
Anatomy, Physiology and Pathology of all Body Systems, and Common Illnesses/Injuries.	**58*	Lecture	Goat Labs. 26* Teaching charts & moulage kits. Reference manual currently being developed.
Traditional Beliefs, Medical Ethics and Ethics within Islam (Students and Ex-Patriots).	**W[a]	Lecture	Translated lectures notes & materials provided at each class by instructors. Major refs for instructors developed. Materials includes:
English	**W[a]	Lecture	
Gynecology and Obstetrics	**W[a]	Lecture	-Where There is No Doctor. -Basic EMT Manual.
Pediatrics	**W[a]	Lecture	-Special Forces Manual. -Medical Specialist Manual.
Communicable Diseases	**W[a]	Lecture	-Emergency War Surgery Manual.
Dental Theory	**W[a]	Lecture	Student References:
Nutrition	**W[a]	Lecture	-GAC Pharmacology Manual. -Translated lecture notes and "handout" materials.
Preventive Med. & Immunization	**W[a]	Lecture	-Basic First Aid Course for Teaching Mujahideen and Future "Assistants".
History & Physical Assessment	**35*	Lecture-30* Practicals-5*	Clinic Rotations: Thal and Chitral
Nursing Skills & Patient Care	**W[a]	Lecture/Demons. Sm Grp Practicals	Hospital Rotation: Thal
Pharmacology and Medication Administration	129*	Lecture-43* Practicals-38* + 2* weekly-48* evening sessions	Clinics & Hosp. Rotations
Clinic Procedures	**11 1/2*	Lecture-5 1/2* Practicals-6*	Clinic - Thal
First Aid - Basic and Advanced Trauma Care	148*	Lecture-80* Demonstration & Practicals-68*	Ambulance Rotation and Several Field Exercises
Teaching Basic - First Aid	**W[a]	Students teach basic course to others	Mujahideen Camps
Surgical & Orthopedic Techniques	**W[a]	Lecture Demonstration Practicals	Goat Lab. Field Exercises

*Complete syllabus with sub-content areas on file AID/REP Islamabad.

W[a]**Total hours for several segments not available. 1st-4 mo. (Phase I & II) calculated plus total First Aid Segment.

- Classroom instruction averages approximately 6*/week.
- Remainder of hours are practical labs, goat labs, field exercises and rotations.
- Rotations include: -Hospital and clinic at Thal.
  -Chitral clinics.
  -Border clinics.
  -Teachings - Mujahideen camps.
  -Ambulance rotation.

Certification and Assignment through cooperative arrangement with Swedish Committee.

TRAINING STAFF:

Afghan Physicians

Dr. Noori	Internal Medicine (male)
Dr. Marghalora	OB/GYN (female)
Dr. Roshna	Internal Medicine (male)
Dr. Shams	Internal Medicine (male)
Dr. Rahimyar	Internal Medicine (male)
Dr. Hashim	Surgeon-non classroom, Hospital Director (male)

4 Translators

Expatriate Staff (current)

*2 RNs	(female)
1 Paramedic	(male)
**2 Physicians	Emergency Medicine (female)
1 Anthropologist	(female)
*1 RN	Acting Training Coordinator and instructor
**1 Physician	Medical Director (non-teaching)

LIMITED OFFICIAL USE

D. German Afghanistan Committee (GAC)

1. Introduction to GAC

a. Location, General Objectives, Funding

In 1984, the Bonner Afghanistan Komitee (BAK) was founded in Bonn, Germany, by a small group of lawyers and doctors with the specific goal of providing humanitarian aid to the populace inside Afghanistan. Referred to more generally as the German Afghanistan Committee (GAC), since January 1985 this organization has worked closely with a group of independent Afghans who have been active in cross-border relief efforts. Primary objectives include the provision of health care to both the civilian and mujahiddin population and the fostering of medical personnel for the future of Afghanistan.

GAC has a home office in Bonn, one German and one Afghan office in Peshawar, a medical training center for dispensers in Sadda, Tribal Areas (approximately 200 Km southwest of Peshawar), and a small clinic and staging area in Miram Shah near the border. Training began in mid-1985 and, at present, there are 12 GAC-sponsored clinics located in the central and eastern regions of Afghanistan (Map E, Page 101). Most of these "medical stations" are staffed by either an Afghan doctor or nurse and two or more GAC-trained dispensers. In addition, European medical missions of German and/or Swiss physicians and nurses undertake periodic journeys to these health units to train, monitor and assist; seven such trips were undertaken in 1986, with a total of six planned for 1987.

AID/REP assists GAC with the support of its health facilities inside Afghanistan, and not with its training activities in Sadda. GAC financing for training activities is obtained from the German government and from private donations from Germany. The Swedish Committee also donates supplies of medicines.

b. Organization Structure and Functioning

(1) GAC Office(s) in Pakistan

The overall impression given by the GAC offices in Peshawar--both Afghan and German--is one of a highly-organized and well-controlled organization. Approximately 20 Afghans are employed in the Afghan office, with 12 working in Sadda and 6 in Miram Shah.

The expatriate Project Coordinator position in Peshawar is presently vacant. Just prior to the arrival of the evaluation team, the Bonn office sent one of its board members to temporarily serve as Project Coordinator for a month. Bonn is now recruiting personnel to fill this position on a permanent basis.

(2) Relations Between Home Office and Field

Past relations between the home office and the field office of GAC have been far from cordial, with many differences taking place about delegation of authority, policy and program implementation. The Bonn office is small, with only two permanent members (a manager and secretary), but with an active and powerful board. Three months ago, the Board dismissed the Pakistan-based Project Coordinator because of the above differences in opinion.

It is anticipated that a new permanent Project Coordinator will be recruited soon and, thus, it is hoped that relations will be smoother between home and field.

The GAC Bonn office does arrange an extensive orientation and recruitment program in Germany for prospective members of the European medical missions to Afghanistan. Video tapes prepared in Afghanistan are viewed and the dangers/difficulties of such an undertaking are clearly presented.

(3) Coordination with Afghans in Pakistan and Afghanistan

(a) Afghan Parties, Commanders and GAC

The GAC approach is to work as independently as possible from the parties and, indeed, in many ways it has established a tightly organized system of its own. The Afghan GAC staff deals with commanders in Afghanistan directly, and when a GAC clinic is established in an area the leading commander must guarantee that all of the populace will have the right to come for medical care--regardless of political affiliation, ethnicity, religious sect, etc. A printed notice to this effect is distributed in the clinic locale in both Pushtu and Farsi. As can be seen in Table 15 which lists GAC's health facilities in Afghanistan, party affiliation includes Mahaz, Ethehad, Hezbi (Gulbuddin), Hezbi (Khalis) and even some mixed and Shiite groups.

(b) General Framework for Service Delivery in in Afghanistan

As illustrated in Map E and Table 15, GAC's 12 facilities are located in seven provinces throughout central and eastern Afghanistan. These medical stations are staffed by 11 doctors, 12 nurses and about 30 dispensers trained by GAC. All receive regular salaries from GAC and are well supported by the organization, the dispensers get Rs 1500 per month.

Staging areas include Miram Shah, near Sadda, and further north from Peshawar. GAC has its own transportation system of six horsemen and some 18 transporters who are responsible for supplying each health facility periodically with supplies. The health units comprise a chain, and during the journey a team passes from one to another.

Sets of medicines, each comprising 450Kg, are sent periodically to each GAC facility, along with salaries, mail, etc.

Excellent records are kept by the medical stations, which are sent to the Peshawar GAC Afghan Office each month. These include detailed daily register books, monthly summary sheets and pharmaceutical logs. It is estimated that a clinic sees an average of 1050 patients each month. Records are not thoroughly analyzed much in Peshawar but are forwarded to Bonn for analysis.

GAC has six coordinators (masul-i-clinic) who travel from clinic to clinic monitoring progress of staff, responses of local communities, etc; they also serve as communicative links between Peshawar and Afghanistan. Videos have also been prepared in a number of regions of Afghanistan. An Afghan physician holds the post of Director of Inside Operations and he plans the work of the coordinators. German/Swiss teams go into Afghanistan for two-three months duration to monitor the clinics and also provide on-the-spot training. Both male and female expatriates make these trips, with female medical personnel treating Afghan women when necessary.

The situation from one clinic to another varies considerably. In some areas, bombings prevail. A number of clinics (five or six) were temporarily closed in recent months due to lack of security, difficulty in maintaining medical supplies, etc. Thus, GAC appears to be striving for quality and not quantity, and does not plan much expansion in number of facilities in the future.

(4) Coordination Between GAC Activities in Pakistan and Afghanistan

Generally, coordination between Pakistan-based activities and Afghanistan-based undertakings is good. With the training activities taking place near the border/staging area in Sadda, news from Afghanistan reaches here first. Also, the dispensers being trained stay for three months, go inside to work and then return for more training--they bring their practical problems and questions with them to training. And, with two or more working in each facility, the absence of one does not cause the unit to cease functioning.

c. Coordination with Other PVOs, CMC and AID/REP

As far as relations with other PVOs in Peshawar are concerned, GAC has sent one student for training in dentistry to MRCA. In addition, GAC is using the manual of standard drug formulary prepared by a German physician with GAC--as are also FM, IMC, MTA, MRCA and the Swedish Committee in their training. GAC also receives medical supplies from the Swedish Committee.

The GAC is an active member of CMC, and it has been utilizing the standard list of medicines set forth by the coordinating body.

The GAC submits detailed reports to AID/REP about its activities both in Pakistan and Afghanistan. Its reports are informative and well organized, with honest accounting of problems encountered. Although earlier it had been submitting physician reports in German, it has now submitted reports which are translated into English.

d. Recommendations

1) Relations between home and field office must be improved. Careful selection of a new Project Coordinator and a frank review and understanding of factors giving rise to the previous animosities will help assure better relations in the future.

2) Data should be sent to Germany only when they have been analyzed initially in the field. Although valuable for fund-raising, information is also necessary for valuable feedback about health needs, curriculum content, etc. An individual should be appointed to accomplish such data analysis in Pakistan--prior to sending the information to Bonn.

2. Educational Component of GAC Program/Project

a. Background

The GAC instructional program was primarily designed to provide trained "dispensers" for the staffing needs of GAC-established facilities. These graduates are expected to provide health care assistance under the direct supervision of GAC-assigned Afghan physicians at specific locations.

As initially planned, students receive 3-4 months of initial training (Phase I) followed by inside experience/assignment, then return for an additional 3-4 months of training (Phase II), with "weakest" students returning first. The start date of the second training phase is communicated by letter/message to GAC facilities approximately 1 month in advance to allow facilities to select returnees. To date, 3 classes of Phase I have been given and currently 8 of an original class of 14 are in Phase II. Students receive salaries and vacation benefits upon the successful completion of the first phase of training and are assigned to facilities based on staffing needs and geographical preferences.

Curriculum content for the second phase is somewhat informally predicated upon student expression of their own areas of need and information received from the inside regarding student weakness/specific disease or injury trends.

Inasmuch as GAC maintains its own logistics chain and system of inside "coordinators", the flow of supplies and integrity and availability of communication/information between inside facilities and outside support systems (including training) is exceptional. It could and should provide a more structured basis for coordinating specific training with service delivery needs. The current accumulation of data received should be used to formulate curriculum and training strategies. (It is not currently being applied to education decision-making in the field.)

The GAC transport and logistics system and the inside physician upgrade (by teams of expatriates) program is well organized and successful. However, to date the dispensers' training component has had less focus or attention to its development or support. In summary, it enjoys the dubious distinction of being a "stepchild" sadly in need of a "fairy godmother"[14].

b. Facilities

(1) Teaching

A classroom located in one of the structures within the GAC compound has been equipped with chairs and tables. While limited in size, it is sufficient for small class lectures/demonstrations. In addition, calf/goat labs are occasionally established out of doors for practice demonstrations. A dispensary and OPD clinic are also used as teaching facilities for student rotations/assignments. Both are poorly equipped at a less than minimal standard for either teaching or service delivery. (Excellent staff, but no tools/supplies).

(2) Service

The OPD clinic and dispensary provide limited health services usually to unregistered Afghan families of the surrounding refugee encampments. These families are registered by GAC on small plasticized cards which are presented each time a family member seeks care (2600 families registered to date). One Afghan physician and four GAC students provide rotating shift coverage for both an AM and PM service delivery. There are alternate days for men and women, with children attending at any time. A 100 patient/day caseload is considered average.

14 The German Afghanistan Committee has not asked and the US Government does not provide funding for any portion of the GAC medical training program team. Nonetheless, GAC invited the evaluation team to its training facility in Sadda to meet and talk with GAC Afghan physician trainers.

c. Course Admission System and Criteria

GAC's inside operation activities affords it an advantage in communication and recruitment of staff and students. Criteria for admission, selection and retention are outlined in Table 16. In addition, due to the current professional Afghan teaching staff, both Pushto and Farsi-speaking students can be accommodated without the need for translators. The number of course participants who have completed all segments/phases has been minimal to date (first 8 now in Phase II). However, with few exceptions, all students trained in Phase I are engaged/employed in inside activities. Four inside Afghan personnel have been killed: 1 dispenser, 1 doctor, 2 transporters. In keeping with GAC's personnel practices, benefits were provided to these families.

Graduate dispensers are assigned to GAC clinics based on numbers of personnel required for the population/area served. Average staffing pattern is 1 doctor, 1 nurse and 3-4 dispensers, plus support personnel.

d. Curriculum and Methodology

The curriculum of GAC is an index/topic list for each of the major subject areas covered (see Table 17). It contains a mixture of diseases/conditions as well as a few procedures. None of the topics have any content or subject matter breakouts. Therefore it is impossible to determine what is being taught, what level of detail or what skills if any are being acquired. The subject areas of Anatomy and Physiology and Eye, Ear, Nose and Throat topics appear to be listed in a systems approach. However other major subject areas such as Internal topics are an index list of diseases from anemia to arthritis with no relationship to systems.

No textbooks, references, lecture materials or student materials are provided to either the instructors or the students with the exception of the GAC pharmacology manual (a recent acquisition).

The methods of instruction are primarily lecture. Very limited "posters" are available (nutrition and ORS). There are no teaching models, charts, audio-visuals or microscopes.

An "occasional" calf or goat lab is conducted (when budget and dinner menu permit) and rotations in the OPD seeing patients daily (also with no equipment). One doctor with two to four students in A.M. and another two in P.M. and approximately 100-150 patients/day equals very questionable opportunities for directed learning.

In summary, the GAC has some very enthusiastic and dedicated young physicians (not teachers) with no curriculum, no equipment and no supplies. Without immediate support, the students have little chance of learning and retaining needed skills.

GAC has advantages of inside communication, logistics, trained expatriate expertise and support. The dispenser training program desperately needs the same level of support and organization.

e. Educational Administration and Faculty

The on-site education administration of the dispenser program is under the direction of one of the faculty members with coordination and assistance of the "medical coordinator" in Peshawar. Three faculty (physician instructors) provide classroom instruction as well as OPD service provision and student supervision. All are Afghans under contract with GAC.

The on-site faculty are enthusiastic, qualified medical professionals. Language and cultural barriers are non-existent and rapport with students is excellent. Prior to their dislocation they were actively engaged in practicing medicine within Afghanistan, rather than in academic/teaching situations.

The instructors are responsible for developing their own lectures and working with students in the OPD. All read English and some are conversant. However, they are limited in the nearly non-existent reference materials, supplies or equipment to develop lectures or practical demonstrations for student development. In addition, teaching techniques and course development were not part of their previous professional backgrounds and they are teaching "from memory".

GAC should seriously consider providing these instructors with some educational technical expertise for course planning and development as well as the needed references and teaching tools.

The "inside" physician upgrade program appears to be quite successful. Expatriate teams/individual physicians/nurses are assigned inside for one to two-month periods of time to work with the Afghan personnel at GAC facilities. The expertise of these expatriates is then shared in a daily working relationship on actual cases in the field. While it is assumed that the teams are both beneficial to the patients and skills improvement of the Afghan medical personnel there is no means measurable to verify this. Currently there are said to be 11 Afghan doctors and 12 Afghan nurses working in GAC facilities. Last year seven expatriate teams worked inside and 3 more are expected to go in shortly. A total of eight to nine are planned for this year. So far three expatriate medical teams have gone or are expected to go shortly. This system appears to provide very consistent "upgrade" opportunities for the inside Afghan medical personnel. However, none of these teams provide any teaching expertise to the dispensers course in Pakistan. GAC should consider strategies to apply some of the cost/benefits of the expatriate expertise to the dispenser classes as well as to inside activities.

Excellent patient records/daily logs are kept by personnel inside including monthly summary reports of types of cases seen and drugs dispensed. These records are brought out by coordinators and data is used for resupply then forwarded to GAC home office. No feedback is received by the education personnel of the dispensers course. However, some may be used in the briefing of expatriate teams. Such data could be used for decisions related to development of education curriculum (i.e., prevalent diseases/injuries and treatment modalities).

f. Educational Recommendations

1) Support and supply the education program and facilities at a minimum: large simple anatomy charts and models; microscope set and slides for teaching, cassette tape machine and tapes of medical terms (English), reference books for physicians (English), first-aid practical kits (splints, bandages, etc.) and basic OPD clinic equipment for service and education.

2) Obtain services of education/curriculum specialist to develop a suitable curriculum and student materials, specific to level and subject matter to be covered.

3) Seek closer cooperation with other PVOs and CMC for education resource sharing.

4) Identify, develop and implement specific skills list system to monitor each individual students performance, completion and level of achievement.

5) Incorporate additional teaching methods such as planned practical/ field exercises, group skill sessions and laboratory sessions to decrease lecture format and reinforce understanding.

3. Monitoring and Evaluation

a. Overview

The German Afghanistan Committee supports and maintains 12 facilities inside Afghanistan, trains Afghan health workers (dispensers) and fields periodic teams of expatriate physicians and monitors who deliver medical care and upgrade Afghan physician skills at the GAC inside facilities.

Through the frequent (two-four month) interchange of these teams of expatriates and monitors, GAC has been able to have a reasonably consistent network of timely communication report data as well as a system for evaluation and monitoring of supplies, staff and clinic performance and needs assessment of current and future significance. It has utilized this information for decisionmaking purposes of subsystems such as dispenser education, supply replenishment, facility location and staffing.

b. Training

A measure of student proficiency in the field is achieved by the GAC two-phase training approach. Students receive a few months' basic training (Phase I), then go inside for experience. While inside they are asked to write down problems they could not handle. When they return for Phase II of the training they are expected to share these notes and other thoughts regarding their "weak" areas. Students then work with physician instructors in classroom and OPD settings to address these areas.

This process provides GAC the opportunity for direct feedback on learning needs of current as well as future students. These identified areas can and should be analyzed in view of curriculum focus for Phase I.

The Phase I basic curriculum has not been fully developed at present. However, as this occurs student evaluation mechanisms should be incorporated to monitor student proficiency in skills as well as knowledge base.

With frequent trips by expatriate physicians inside, GAC should consider developing a physician evaluation tool for assessment of the Afghan doctors assigned to allow for identification of weaknesses/strengths of each Afghan doctor and guide the activities of the frequently rotating expatriate physicians in planning their "upgrade" visits in the future.

c. Inside Facilities

GAC medical assessment teams/monitors are fielded with some degree of regularity. Seven teams went in during 1986 and eight to nine are proposed for 1987. More than 40% of German/Swiss medical personnel have been in more than once. They perform medical assessments, review clinic reports, observe procedures and discuss staff areas that need improvement. In addition, they provide upgraded/current medical knowledge and skills on an informal basis working directly with the Afghan physician.

These teams perform a broader evaluation function in that information is then used for decisionmaking at several levels (i.e., clinic placement, site changes, supply needs and future expansion of health stations and logistics systems).

While not without risk (teams have been "ambushed"), the GAC integrated approach to monitoring, evaluation and system control of inside activities is excellent.

Records are meticulously kept of all activities and supplies. Monthly summary tools have also been developed and have currently been revised in format to collect information compatible to forms used by UNHCR. This system may provide future compilation and cross-use of data. GAC should consider some further analysis of this data for disease trends by regions and educational needs/changes to curriculum for future students as well as planning for inside physician "upgrades" or service expansion.

d. Staff

Expatriate staff are recruited, screened, briefed and trained by the home office. Mission information from former staff is shared and the hazards and difficulties visualized through use of video tapes of former missions and discussions with the staff "evaluators". Questionable applicants are not accepted or counseled for their own decisions to withdraw. This process has been imminently successful. However, some mobile teams have not been able to complete the total expected duration of their missions due to increased war activity, destroyed supplies or difficulty with access to some areas through various commanders.

Some missions were terminated early for the purpose of transporting severely wounded patients back to Pakistan health care facilities (usually IRC Hospital).

Mobile missions use vehicles/caravans (jeeps, pick-ups, ambulances, horses).

Several of GAC's expatriate medical teams have had harrowing experiences and very, very "close calls". To date, there has been no loss of life of expatriates. However, GAC Afghan personnel have been injured and killed.

Debriefing of expatriates occurs in the field and to some extent at the home office. Written reports from each physician is required and synopsis or summaries are included in GAC reports.

At this time, no formal performance appraisal is made of expatriate staff. GAC may wish to consider the development of a simple evaluation tool which could be completed by the field and shared with the home office for future recruitment information as well as staff records and development.

e. Recommendations

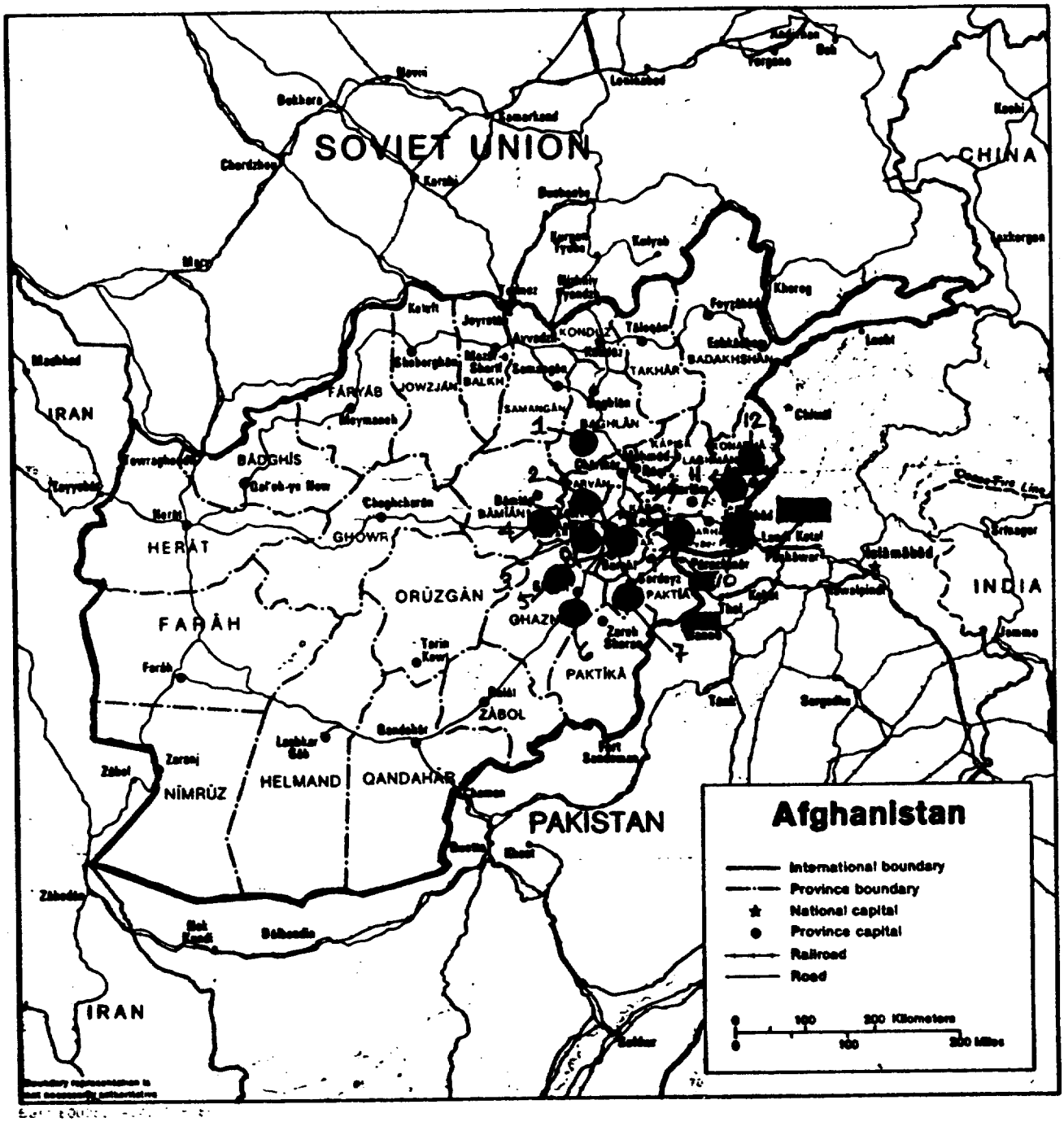
1) GAC should develop an integrated overall written strategy for monitoring and evaluation of the various components of its total project (i.e., education-dispensers, Afghan physician upgrade, staff, inside clinics, etc.).

2) Current data should be reviewed and needed additions/deletions identified. The plan should be specific in detail for guiding implementation in the field/education programs. It should be management-oriented, user-driven and geared toward the "minimum necessary".

3) Data collected should be reviewed annually to determine their utility for problemsolving and decisionmaking and changed/discarded as appropriate, with consideration of impact on subsystems communicated to all levels.

4) GAC should submit physicians reports in English along with their quarterly reports detailing the objectives and results of each medical mission.

MAP E: HEALTH FACILITIES OF GERMAN AFGHANISTAN COMMITTEE (GAC)
IN AFGHANISTAN
(July 1987)



*Numbers refer to Table

[redacted]

TABLE 15

HEALTH FACILITIES IN AFGHANISTAN
GAC - GERMAN AFGHANISTAN COMMITTEE

As of July 1987

12 Fixed Units ----_ All Clinics

PROVINCE	VILLAGE/TOWN	PARTY AFFILIATION
1. Baghlan	Tala/Barfak	Mahaz (Gailani)
2. Wardak	Chak-Wardak	Independent (Mix)
3. Wardak	Jagatu	Harakat
4. Wardak (Hazara Jat)	Chilam Jai	Shia Groups
5. Ghazni	Torgam (Greater Ghazni)	Etehad (Sayyaf)
6. Ghazni	Khogani	
7. Paktia	Zormat	Karakat, Manzoor
8. Logar	Baraki	Hezb (Gulbuddin)
9. Nangarhar	Khugiani	Mahaz (Gailani)
10. Nangarhar	Shalman	Hezb (Khalis)
11. Konar	Sokai	Hezb (Gulbuddin)
12. Konar	Shah Alam	Hezb (Gulbuddin)
PLANNED CLINICS:		
1. Baghlan	Buzdara	
2. Takhar	Ishkamesh	
(Not on Map)		

[redacted]

TABLE 16

GERMAM AFGHANISTAN COMMITTEE

Admission and Retention Criteria

Recruitement: Commanders' recommendation. Screening and interview by GAC Afghan staff/leadership.

Criteria:

Admission:
- -12 grade/equivalent minimum education requirement.
- -Basic oral and written examination.
- -Non-migration of immediate family members.
- -Pushto or Farsi speaking.

Retention:
- -Demonstrate proficiency of knowledge and skills to satisfaction of instructors. Variable oral/written exams at discretion of instructor.

Faculty:

Afghan: 3 Physicians - Education preparation areas include:

- Internal Medicine
- Pharmacology
- Eye/ENT & Dermatology

1 Coordinator - 3yr. Medical School

1 English teacher

Expatriot: Short term physicians assigned inside to upgrade and enhance physician skills of Afghan physicians at inside facilities (usually surgeons).

TABLE 17

GERMAN AFGHANISTAN COMMITTEE
Course Structure - Certification and Assignment Specifics

Course: MEDICAL AIDE - 6 Months

Anatomy and Physiology	24*	Instructor developed lecture - occasional goat/calf lab	Minimal to non-existent, with exeption of GAC Pharmacology Manual. Students take notes. Some instructor developed handouts. Minimal to non-existent audio-visuals, models, charts, demonstration equipment or Instructor Reference Books.
First Aid	30*	Lecture/ demonstration	
Parasitology & Bacteriology	48*	Lecture	
Surgical Topics	60*	Lecture	
Internal Medicine Topics	60*	Lecture	
Sanitation and Preventive Health	24*	Lecture	
ENT	24*	Lecture	
Eye	36*	Lecture	
Skin Diseases	48*	Lecture	
English	60*	Lecture	
Philosophy of Islam	60*	Lecture	
Nutrition	24*	Lecture	
OPD Clinic Rotation 4 Students AM or PM to each shift daily	24*	Supervised Experiences	

Certification and Assignment:
- Termed "Dispensers".
- No certificate awarded, expected to be assigned and employed only by GAC.

Pay Scales:

Dispensers: - Rs. 1700/mo with 45 days/yr paid vacation; one year contract.

Inside Physicians: - Rs. 5000/mo with 4 months/yr vacation (2 mo. inside-1 mo. out), one year contract

Assignment:
- Assigned to specific GAC facilities; work under supervision of qualified physician or nurse.
- Supplies allocated to facility and delivered by GAC logistics coordinators directly to facility.

E. Medical Refresher Course for Afghans (MRCA)

1. Introduction to MRCA

a. Location, General Objectives

The MRCA facility is centered in a 30-bed teaching/surgical hospital in Peshawar. This hospital was opened in April 1986 with the specific objective of providing refresher training to Afghan health workers. MRCA's work is thus complementary to that of other PVOs, for it receives students from these organizations and provides them with tailor-made practical training in specialty areas: surgery, physical therapy, dentistry, x-ray and laboratory techniques. In contrast to the other PVOs reviewed here, MRCA does not have a system of clinics inside Afghanistan; its focus is rather upon training.

To date, approximately 46 Afghans have been trained at MRCA and, of these, 41 have returned to work in a variety of health facilities sponsored by other organizations inside Afghanistan.

b. Organizational Structure and Function

(1) MRCA Office in Pakistan

The development of the MRCA project is largely due to the efforts of a dynamic French anesthesiologist who worked in Afghanistan with AMI in 1983-1984 and perceived the need for such specialized refresher training. She is now Director of the MRCA Hospital in Peshawar, which is housed in a large renovated building outside the city that had previously been a hotel.

On the staff are 4 French expatriates (Director/anesthesiologist, surgeon, dentist and physical therapist), 7 Afghan technical health workers and approximately 20 support staff. (Note: Of special interest, it was mentioned that the expatriate post of physical therapist would probably not be necessary to fill again because the Afghan assistant has become qualified enough himself to assume this post.) Expatriate staff are recruited by the home office, with final selection in the hands of the Director. It is especially difficult to recruit surgeons who will remain for more than 3 months, and staff turnover is high. In this regard, concern was voiced by the staff themself about training continuity. Administration is in the hands of the Director, and mention was made that an Administrative Assistant (Afghan) was needed; an individual informally working in this position had recently left.

MRCA does not select its students; they are rather referred to it for short periods of training (a few weeks to a few months) from six major PVOs based in Peshawar. These PVOs, along with the number of their students coming to MRCA in 1986-1987 include the following: MTA - 23, SCA - 11, FM - 5, NCA - 2, GAC - 1 and MDM - 1.

Although the present facility is adequately equipped with operating and sterilizing rooms, dental clinic, laboratory, library, dormitory, etc., MRCA is planning to move to a new site in approximately one year. This will be a multipurpose "professional training center" in the Hayatabad section of Peshawar near the Afghan refugee camp of Kacha Ghari. The center will embrace not only the MRCA teaching/surgical hospital but also the following PVOs: MTA, ASYAR (Apprenticeship Scheme for Young Afghan Refugees/Belgium), TTC (Teacher Training Center/Belgium) and the Sandy Gall Appeal for Afghanistan (England). Resources for this multi-organization project are being obtained from the ECC (European Community Commission), with the remainder from other European donors. The participating PVOs believe that this group approach will allow for more coordination and also reduce physical costs.

(2) Relations Between Home Office and the Field

The home office is small and rather insignificant as far as MRCA activities are concerned. It was created for the project in October 1985 in Paris and employs only one individual. The office is called Soliderite/Afghanistan and it aids in recruiting, fund-raising and communicating with other PVO offices in Europe, etc.

(3) Coordination with Afghans in Pakistan and Afghanistan

MRCA receives students who have already been nominated by commanders and screened by the Alliance Health Committee for other PVO training projects. Thus MRCA itself has little direct contact with this process.

The Director mentioned that students from different party affiliations and different PVO affiliations meet at MRCA and may form a team among themselves to later work together in Afghanistan.

As mentioned above, MRCA sponsors no service delivery inside Afghanistan. Students return to work in their own original PVO system, etc.

c. Coordination with Other PVOs, CMC, and AID/REP

As noted above, MRCA coordinates with a variety of PVOs in that it receives their students for specific training. Indeed, all of the PVOs reviewed here except MCI in Quetta and IMC send their students to MRCA.

MRCA also takes advantage of IRC's translation services at the Health Education Resource Center in Peshawar to have its various lesson outlines translated into Farsi.

The new multi-PVO "professional training center" in which MRCA is participating is another indication of its coordinating ability.

It is also an active member and supporter of CMC.

MRCA submits timely and carefully-written reports which clearly describe its progress and problems. Sometimes the originals appear in French which are then translated prior to submission to AID/REP.

d. Recommendations

1) The Director of MRCA should hire an Administrative Assistant (Afghan) soon to ease her heavy workload.

2) All efforts should be made to recruit expatriate staff for a longer period than three months to ensure project/training continuity.

2. Educational Component of MRCA Program Project

(a) Background

The Medical Refresher Course for Afghans (MRCA) was organized to provide additional training in surgical areas for Afghans already working in the health field inside Afghanistan. More recently it has expanded this offer to include graduates of other PVO health courses either within their current course or as an addition following it. To date, 43 students have been accepted for 3-week to 3-month courses in such areas as surgery, physiotherapy, x-ray, dentistry or anesthesia.

MRCA is primarily a teaching service surgical hospital serving the Afghan community of Peshawar. It does not maintain "inside" clinics or facilities. Graduates of this/these program options are returned to the sponsoring PVO/organization who assigns, equips and supports them in the inside facilities. MRCA has been open approximately 16 months, during which time extensive renovations to the complex have occurred. Due to previous difficulties of equipment and recruitment of qualified personnel the laboratory component of the program has not as yet been finalized. With resolution of these problems it is expected that students will be afforded this additional option in the future.

To date, students have been accepted from the programs of MTA, MDM, FM, GAC, SCA and non-aligned inside students. To the best of MCRA's knowledge all have returned inside with the exception of 3-5 and 1 has been reported killed.

b. Facilities

(1) Teaching/Service

The current complex is a self-contained structure having both students and patients. All essential hospital and support component areas are in operation including separate two-bed hospital rooms for male and female patients, operating theater, separate consultation (OPD) rooms, laundry, kitchen, x-ray, dental and physiotherapy rooms. In addition, small classrooms and study rooms are also included. The MRCA administrative offices are also within the component.

This facility, for the standards of the country, is well equipped, organized and staffed for 24 hour/day care of in-patients and emergency situations.

Its purpose is well defined and all systems reflect its surgical focus and training intention. Patients and staff alike express their satisfaction with both the surroundings and services provided.

Students have the option of dormitory facilities within the compound or may remain with the sponsoring PVO facilities.

Expatriate staff are housed elsewhere in the city but are linked by on-call phone system as well as daily duty worker coverage for emergency cases.

Thirty Afghan employees are involved in support service and staff roles throughout the departments and administration.

(2) Service

The hospital provides for 28 in-patients, however it is expandable in terms of bed space in certain rooms (children's). Four more rooms are expected to be available shortly.

The OPD and dressing room provides service to approximately 12 patients/day and performs follow-up care for discharged patients.

The physiotherapy and dental departments each see 12-15 patients/day on an out-patient basis. Both external and internal patients are accepted for physiotherapy while external patients only are accepted for dental service.

Surgical consultations are performed twice a week (Tuesday and Saturday) and surgical scheduling is done from these screenings. (30-40/week).

Students elect the specialty area and work with the appropriate expatriate and Afghan staff in 1-3 or 1-4 small group ratios to learn the skills required.

c. Course Admission Criteria and System

The course admission criteria is outlined in Table 18. This criteria has evolved from the first concept of accepting students directly from Afghanistan to present recruitment which combines both direct students and referrals from other PVOs/organizations for training as part of the current program or as an optional follow-up.

Students who apply are screened and given a basic general knowledge examination. Accepted students spend 1-2 weeks in the general hospital wards prior to assignment in the department of the "specialty". In as much as there are limited positions in each department only 1 to 3 students per department are accepted at any one time.

The length of stay (course) for each student is predicated upon the ability to perform techniques and understanding of the essential information presented.

Several students have completed training in multiple "specialty areas" while others have concentrated on 1 or 2 specialties. Since April 1986 the maximum students in any given month to date has been 14 with 10-12 being the average.

The heaviest patient case load for this period has been dental patients. Patients within other areas being approximately equal in number.

d. Curriculum and Methodology

Students in each specialty area are offered a curriculum which is specific to that specialty. (Table 19 outlines specialty areas.)

Each area has defined subject matters and skills and students receive translated materials (IRC service) on each subject including illustrated worksheets on specific subjects (burns, fractures, anesthesia, etc.).

The primary methods of teaching include lectures, small group discussions, demonstrations and daily experience working with patients in their specific departments.

Theory and practice are well integrated and level of detail is kept to the essential information required. The focus is on practical application and skill proficiency.

Students are evaluated continuously with counseling and guidance provided by an available staff. In addition a written evaluation is performed at the conclusion of their individual program detailing motivation, organizational ability, specific techniques learned and proficiency, as well as attitude and working relationships to staff and patients. These formal evaluations are discussed with the students and sent to the sponsoring PVO/organization. The variable length program offers students the time to perfect skills and individualize their learning needs.

Surgical procedures taught are basic (incision/drainage, fractures, suturing wounds, etc.). While more complex procedures (abdominal surgery) are performed by expatriate surgeons. Students are not taught to perform them independently, rather to assist and to understand the general aspects of the operation.

Students are taught basic anesthetics and anesthesia procedures. They are limited to IV and IM perfusions to allow students to maximize proficiency of skill and minimize potential patient complications.

Similarly, the other specialty areas have also limited their focus to basic skills and procedures. This approach affords the students the best opportunity to learn essential material and build essential skill proficiency in relatively short periods of time, while also affording the maximum potential for delivery of good quality care for these defined skills/procedures.

In terms of preference, students appear to seek the opportunities of surgical areas as their first choice (a consistent pattern across all training programs). This surgical specialty also requires the greatest time due to deficiencies of students' foundation, education and the complexity of the skills required. All teaching staff voiced the conviction that only specific surgical techniques be taught to avoid the serious potential of misapplication of knowledge by unprepared "doctors" in the field.

e. Educational Administration and Faculty

Administration activities are the responsibility of an expatriate female physician (anesthesiologist) who has served as the Hospital Director since the inception of the program. She is assisted by an Afghan administrator and secretary. Expatriate staff include a surgeon, physiotherapist and dentist. Each are assisted by Afghan personnel/ assistants, including one assistant surgeon, one nurse, four nursing assistants, an assistant physiotherapist, dental surgeon and anesthetist. One Pakistani nurse is also part of the professional staff. All Afghan staff are salaried employees of MRCA.

Expatriate staff are the instructors for the specialty areas and students have the same instructor throughout their specialty time.

Expatriates are recruited and screened through the "home office" with final selection by the Hospital Director. The greatest difficulty to date has been the average three-month duration of surgeons. Other personnel have remained for longer periods of time. To date, the laboratory component and qualified staff have not been finalized.

The staff are motivated and enthusiastic. They feel the greatest problem they encounter is one of time limitations to assure quality graudates particularly in surgical areas.

f. Educational Program Recommendations

1) Develop and implement a specific skills list system to monitor each individual student's performance, completion and level of achievement.

d. Staff

MRCA staff is a mixture of Afghan and expatriate health care professionals with Afghan support staff. Expatriate staff are selected from applicants by the field director/administrator to fill specific service and teaching roles. The team is involved in decision-making, planning and evaluation of the daily activities of both the hospital and instructional program. Staff evaluation is informal and feedback provided by peers and administrator. MRCA may wish to consider developing a more formal mechanism for recruitment, selection and evaluation of expatriate staff in the future for records of MRCA and personal growth of the individuals.

e. Recommendations

1) Develop system for obtaining relevant inside information regarding student performance and educational needs.

2) Develop and implement overall written strategy for monitoring and evaluation of components of project (i.e., education, staff, service).

3) Data collected should be reviewed annually to determine utility for problem-solving and decision-making.

4) Data instruments should be reviewed simultaneously for needed changes/revisions.

Previous Page Blank

TABLE 18

MEDICAL REFRESHER COURSES FOR AFGHANS

Admission and Retention Criteria

Recruitement: Students are selected from applicants who have completed other health provider courses of PVO's, primarily MTA, MDM and F.M. Have previously been approved by commanders and Alliance..

Criteria:

Admission:
-Successful completion of previous courses.
-Application and Interview.
-Basic English Exam.

Retention:
-Final Exam.
-Written evaluation on completion of course shared with student and "sponsoring" PVO.

Current Instructors:

Expatriot: 3 Physicians
-1 Surgeon (Male)
-1 Anesthetist (Female)
-1 Dentist (Male)

Afghan: 1 Surgeon
1 Nurse

Pakistani: 1 Nurse

TABLE 19

MEDICAL REFRESHER COURSES FOR AFGHANS

Course Structure - Certification and Assignment Specifics

Courses - Specific Refresher Subject Areas 3-6 Weeks (Variable Duration)

*Subject Areas

Basic Anatomy and Physiology

Specific procedures related to surgical subjects including:

--Anesthesia
--Fractures
--Infections
--Absesses
--Burns
--Amputations
--Wounds
--Pre & Post Operative Care
--OPD Surgical Consultations

Physiotherapy

Radiography

Dentistry

Certification:

Recruiting/sponsoring PVO's receive written evaluations regarding specific skills learned. Students may return for additional specialty areas. Usual time frame 3-6 weeks (surgery may be 1-3 months) per each area.

Assignment:

Are assigned "inside" through sponsoring PVO or Swedish Committee.

* Course outline and objectives on File AID/REP Office, Islamabad.

Students choose from 1 of 4 specialty areas
Receive course lecture and practical experience related to area chosen.

F. Medecins du Monde (MDM)

1. Introduction to MDM

a. Location, General Objectives

This French medical association was created in 1980 to aid populations throughout the world facing disasters; it works internationally in 18 countries today[15]. French doctors of MDM first went inside Afghanistan in 1980, and since 1981 expatriate teams have made regular trips of three to five months duration to Wardak Province.

At present, MDM sends French medical missions to two general regions in Southeastern Afghanistan: (1) Wardak and Ghazni and (2) Kunar (Map F, Table 20). In Wardak an underground hospital and two distant satellite dispensaries exist. In Kunar MDM mobile teams are engaged in a vaccination campaign. Some training of local Afghans (12 nurses, 10 vaccinators) also takes place within Afghanistan.

b. Organizational Structure and Function

(1) MDM Office in Peshawar

MDM has no formal office in Peshawar because, to date, the majority of its activities are within Afghanistan; Peshawar is used simply as a staging location to prepare for Afghanistan. Its base is in the French House, in Peshawar which also contains staff representing MSF, Guilde du Raid and AFRANE.

Its new representative, a French physician, has recently returned to Peshawar from a two-month journey inside Afghanistan and a one-month visit to Paris.

(2) Relations Between the Home Office and the Field

Relations appear to be very positive, with detailed debriefing occurring whenever a team returns to Paris from Afghanistan. The representative states that he as a physician and the Coordinator (American) in Paris who is an Afhanistan specialist/journalist complement one another nicely.

MDM in Paris is a large organization, with the Afghanistan project having its own small office.

15 Other countries in which MDM is active include Chad, Sudan, Nicaragua, Brazil and Lebanon, etc.

Intensive orientation training periods of 15 days for expatriate staff are held by the home office in France, during which participants learn about Afghan culture, basic Farsi/Pushtu, medical and surgical conditions in the field, horse riding/care, etc. In addition, they are briefed about the training curriculum for Afghan nursing students inside Afghanistan and what they will be required to teach when working with them.

(3) Coordination with Afghans in Pakistan and Afghanistan

As shown in Table 20, MDM coordinates with two major political parties: Mahaz (Commander Wazi Amin Wardak) in Wardak and Jamiat (Commander Walid Majrhu) in Kunar. It is noted by the expatriates that now the local communities in these areas know and trust them--and have even composed songs about the French doctors.

MDM communicates mainly with the strong, well-organized commander in Wardak; in Kunar, however, the commander is not as powerful and thus MDM communicates with Jamiat more in Peshawar--and even with its representatives in France.

The commanders themselves send names of local candidates for nurses training or for vaccinating teams.

General Framework for Service Delivery in Pakistan

The health facilities of MDM comprise a small, well-organized system which has taken a number of years to establish; the general framework is expatriate, comparatively closed and controlled (Map F, Table 20).

Wardak/Ghazni

Approximately three teams of French medical personnel rotate into the MDM hospital each year, each for a period of four months[16]. MDM has its own horses, motorcycles and even lorries to provide transport for people and supplies.

The hospital is approximately 150 Km south of Kabul, and it takes seven days by horse to travel there from the border (Map F)[17]. Located at the hospital there is a surgery wing, laboratory, pharmacy and an OPD which sees approximately 80 patients a day. Five months ago two French doctors began to train some 12 Afghan nurses.

16 MDM estimates that the total cost of fielding an expatriate on one of these medical missions is $5,892.

17 GAC also has a health unit/graduates working in the region. There appears to be some rivalry between these various facilities as far as "turf" is concerned.

At a southern branch dispensary at Jagatu-Ghazni (in Ghazni Province) there are two French doctors, one expatriate veterinarian and a British individual who translates for the French team members to the Afghans who understand English.

Kunar

In this eastern province on the border, fighting has been heavy recently and the MDM project there has been cut back accordingly. Expatriate mobile units composed of both men and women along with ten Afghans conduct vaccination campaigns in a series of 20 villages in the Sokai Valley. With five years of experience in developing its cold chain, MDM has vaccinated 500 children (tetanus, tuberculosis, measles, etc.) and 200 adult females (tetanus).

MDM presently plans/now wants to conduct an evaluation of the vaccination program and also conduct some general epidemiological surveys of the populations in the areas in which it is working. Two years of clinic records from Jagatu are awaiting analysis which will be brought to Peshawar in the near future. It is not clear at this time if these will be analyzed in Peshawar or in Paris.

The representative is about to leave for a survey of the northern provinces, in hopes of establishing a health center in either Faryab or Badghis with Jamiat party support.

(4) Coordination Between MDM Activities in Pakistan and Afghanistan

At present, MDM's activities are all Afghanistan-based. MDM hopes in the near future to set up a vaccination training center in Peshawar.

c. Coordination with Other PVOs, CMC and AID/REP

One MDM student is presently studying at MRCA; a few others have also received training from FM, IMC and MTA. MDM is anxious to send other Afghans to these training courses too.

MDM is a member of the European Coordination Committee for Afghanistan, and is an observer at CMC meetings in Peshawar. It plans to become a full member of CMC this year.

The representative is interested and stressed the need for coordinated evaluation of PVO health-related activities inside Afghanistan.

Reports are submitted to the AID/REP office through Americares. The reports generated from France are more general and less informative than those recently obtained from the Peshawar representative. With the retrieval of the Wardak clinic records, report content and detail of reporting should perhaps improve.

d. Recommendations

1) MDM should be encouraged to involve Afghans more in its expatriate system of health care delivery--not only as students or nurses but as project coordinators or possibly as analysts of the clinic records. Granted, this is not without difficulties, but at present MDM appears to be working somewhat within an expatriate vacuum.

2) MDM should be encouraged to analyze its two-year supply of clinic records in detail. Perhaps CMC has a role to play in this.

3) The MDM interest in evaluation should be encouraged and coordinated with similar desires of other PVOs. Multinational teams should be sent to observe various health units within Afghanistan. Here again is a role for CMC.

4) Strategies to enhance new sources of funding should be pursued.

2. Educational Component of MDM Program/Project

a. Background

Medecins du Monde, while active within Afghanistan since 1980 in the area of health and immunization services has only recently implemented a teaching program. Activities now include a process for the education of health workers serving within its facilities.

The first group of students began instruction five months ago in what is described as an "individualized" program of classroom and practical service experience. More structured education systems and formats are not yet in place/developed.

Previously MDM had encouraged workers to attend training programs offered by other PVOs within Pakistan (FM and MTA). Three or four in the last two years have done so.

With the continued need for qualified trained personnel in its facilities, MDM has moved toward the education of its own students with training and service activities combined and conducted within Afghanistan. No graduates have yet been produced. However, upon completion they are expected to work under the supervision of qualified health professionals and will be known as Afghan "nurses". With further experience and demonstrated proficiency, some may practice independently in MDM outreach clinics with periodic supervision from expatriate physicians.

b. Facilities

(1) Teaching/Fixed Service[18]

MDM facilities located in or near Wardak, Ghazni and Kunar are the sites or bases for MDM facilities and students. Expatriate teams are located or based in these areas from which "outreach" projects can be undertaken. Wardak Hospital is the primary facility with an average war-related service caseload of 5-10% and daily 8-10 new hospital admissions of all categories.

In addition to hospital cases from the local area, this facility is the receiving and support facility for three current and one planned satellite clinics/dispensaries located in outlying regions/areas.

The Wardak facility supports a TB treatment program including laboratory services. This six-month treatment regime is conducted by Afghan "nurses". Of the 100 patients enrolled in the treatment program, to date, only ten have dropped out.

The outreach clinics at Ghazni and Kunar report a caseload average of 80-100 patients per day. Both are used as student training facilities and are staffed by Afghan and expatriate personnel, either on a "permanent" basis or by periodic expatriate physician visits when all Afghan staff have been assigned. Currently, six expatriate medical personnel are assigned to MDM facilities inside (four physicians, one nurse and one veterinarian[19].

Patient case records from these service facilities are maintained at each facility and collected/returned by teams returning from assignment. These had been submitted over the last two years to the Swedish Committee, however, they will now be maintained by MDM for computerized input of data and a system of relay of records (in and out with teams) instituted.

Currently, data is being used for gross analysis of supply needs, trends of diseases and number of patients treated.

18 The US Government does not finance the MDM training program. In 1987 partial funding was provided for a pilot immunization program (see Facilities, Item 2b).

19 Veterinarian services are an essential component of MDM activities inasmuch as the logistics and outreach services are dependent upon MDM's own animal transport system.

(2) Mobile Immunization Program/Service

Following a survey mission in 1986, a pilot immunization program was developed by MDM to test the feasibility of providing this service to selected areas (20 villages).

The first phase of immunizations has been completed in the Kunar area by expatriate health care teams (physicians and nurses) supported by Afghan interpreters and assistants.

Teams are split into two sections. One section or advance group enters the communities, establishes relationships, promotes the program and provides basic health care to the local population. The second section or vaccination team follows the advance group a few days later and administers the immunizations and establishes the patient recordkeeping system which remains with the established community leadership for use during the second follow-up immunization visit (several months later).

This two-section team effort continues from village to village.

Constraints on locations are dependent upon time and distance from generators maintaining cold boxes. (Maintaining cold chain in some areas with use of ice packs and specially-designed backpack with a 24-hour time/safety limit.)

To date, 20 villages have received the first of a two-series immunization program (polio, DPT, measles and BCG). (Polio and DPT to be repeated in second series.) Tetanus vaccine was also offered to women of child-bearing age and adult mujahiddin. Acceptance by women varied in each village. However, house-to-house administration by personnel increased the cultural acceptance factor in some villages.

The Kunar area field test of this system was carried out by two male physicians, one female nurse and two Afghan transporters. The mission took approximately two months to complete:

-- 500 children up to seven years of age were immunized with the first series;

-- 200 women received tetanus.

The second phase of the series will be given this fall and planning is underway for the formation and logistics of these teams.

Evaluation of the percentage of population completing both phases of the immunization program will not be known until this second team returns and statistical data can be completed.

MDM has been compiling immunization data and information for several years. Currently, it is being translated and reports will be forthcoming to AID in the near future. MDM estimates it has immunized approximately 12,000 children for measles since 1983 and 2,000 for DPT and polio over the last two years. The current endeavor is a broad spectrum approach to cover TB, tetanus and the childhood diseases using a two-series approach with newer French-developed vaccines (PEV) (which only requires two rather than three DPT injections).

The potential for replication or expansion of this program will be dependent on, among other factors, continued proven success with the modified cold chain systems in other areas/locations, an acceptable percentage (75-80%) of targeted population who complete both phases and the development and training of Afghan personnel to support and increase this activity. The evaluation of this activity should be carefully validated for future decision-making. The potential benefits to the Afghanistan population is indeed significant and is the only project of this type currently demonstrating capability to implement activity within Afghanistan.

c. Course Admission Criteria and System

Currently, all training activity is carried out at MDM facilities inside, primarily Wardak Hospital and clinics. Students are recruited by commanders and no specific criteria for selection has been formalized. MDM is non-aligned with parties and accepts students from various commanders. Table 21 summarizes the informal admission and retention "system".

At present, 12 students are receiving "individualized" instruction as Afghan "nurses". This first class began approximately five months ago. Duration of "course" is open.

Students work under the supervision of expatriate medical staff, with course work for one to two hours in AM and PM and practical experience in the facilities daily. The number of students to be trained is to meet specific staffing needs. The goal of MDM is to eventually turn over basic health units (clinics) to Afghan "nurses" in a satellite referral/cluster system around a hospital or major clinic facility. In addition, MDM proposes to also use these trainees for vaccination programs in selected areas where basic health services are provided concurrent with vaccination/immunization programs.

d. Curriculum and Methodology

No curriculum or student materials were available ("Afghan Nurses Training") for review. Subject areas are to include: basic anatomy and physiology, pharmacology, public health and hygiene, nutrition and pathology of specific disease entities, as well as immunization skills and theory.

e. Educational Administration and Faculty

The activities of the MDM project are administered by the "home office" with assistance and coordination from the expatriate field personnel in Peshawar.

Expatriate medical teams are fielded for mission-specific assignments which differ in focus and location.

Some perform immunization projects while others staff facilities and perform "faculty" functions for the Afghan "nurse" program.

Expatriate personnel are recruited, screened and trained in France. Training consists of country briefings, culture, history and language, as well as horseback riding and medical/teaching specifics. Recruitment has been difficult particularly physicians. Personnel do not receive a salary, however, those who serve longer than three months receive $500 per month after their voluntary period. To date, only one assigned individual has not been successful in the field.

Approximately 30 expatriates per year are assigned and of these one-third are female. Average length of assignment is four months. The most difficult assignments/projects have been those related to women and child health activities. Currently, MDM is seeking a French nurse who speaks Pushto/Farsi to pilot a women's health program with traditional midwives (future planning). At present, the "Afghan nurses" educational offering is being given by two physicians assigned inside at Wardak.

f. Educational Program Recommendations[20]

1) Develop written basic education plan/structure for training of Afghan nurses including:

- -- specific recruitment and selection criteria and mechanisms;
- -- specific basic curriculum content and subject matter for each area taught including identified skills and methods of instruction;
- -- student monitoring and evaluation system for education structure;
- -- appropriate subsystems to support program.

20 The MDM Afghan nurse program is not funded by the US Government.

2) Implement and support education plan/structure with appropriate staff, material and supplies.

3) Seriously consider addition of education specialist to design and develop education program.

4) If/When SUD/MDM-AVICEN training program funded, apply above recommendations to this education offering, before implementation (Table 22).

3. Monitoring and Evaluation

a. Overview

In April 1986, MDM was requested to provide periodic reports to Americares who would forward reports to AID. In addition, MDM was requested to provide specific information on a six-month basis.

To date, two retrospective reports have been forwarded. These yearly reports while detailing specific financial information and justifying program changes did not provide substantive information on each facility. Particularly absent is any reference to specific objectives and performance/accomplishments for the period (i.e., number of teams, number of patients treated, medical team assessment of trainees, etc.).

While specific actions/problems are briefly discussed, no clarification on specifics is provided regarding the problems or what exact decisions/modifications were made.

A subsequent visit by team members to MDM elicited verbally some of the information previously requested. However, this verbal information should be officially reported in writing from MDM.

b. Training

Verbal information received by team appears to include minimal education/training monitoring or evaluation systems developed. At this time, the education program is very fundamental in its development.

c. Clinics/Inside

No information has been received by AID or the team related to the caseload, effectiveness or evaluation of activities related to patient care facilities inside. (Previous data may have been lost by another organization who was collecting them.) Current data is not kept in the Peshawar office but forwarded to the home office.

Little information related to content as feedback for use in the field is apparent. It may be used by home office in briefing of teams.

The previous vaccination programs are currently being evaluated by the home office and supposedly will be shared in the near future.

A more thorough analysis and evaluation of the first phase of the Kunar pilot vaccination program is planned following the completion of Phase II and an analysis of its effectiveness determined.

d. Staff Evaluation

No field mechanism for stressing staff performance evaluation exists. Debriefing of personnel may occur at the home office, however, there is no written evidence of this.

The current staff evaluation (feelings) of inside activities and systems of recruitment and assignment activities are very positive.

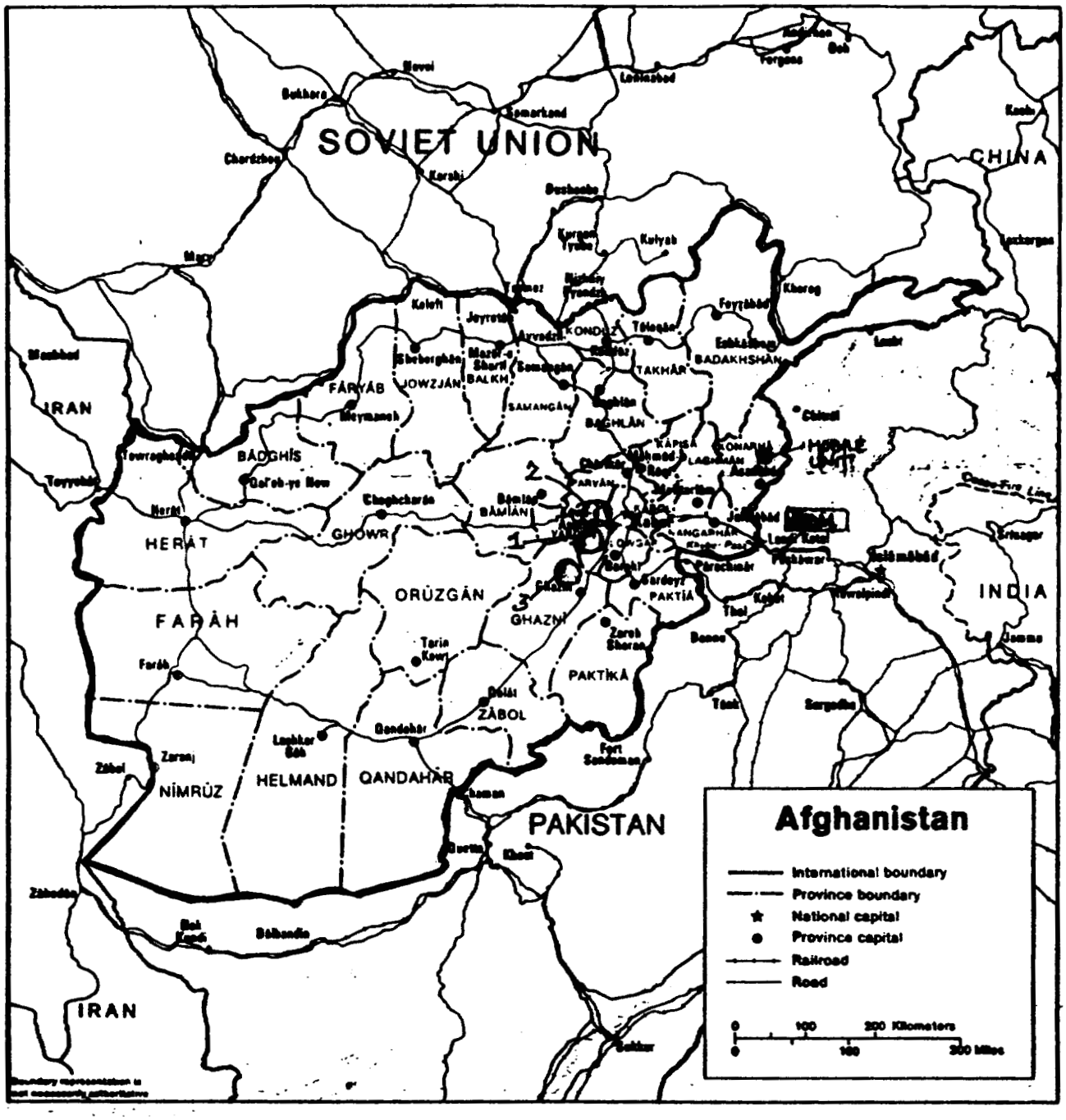
e. Recommendations

1) Medecins du Monde should develop an overall written strategy for monitoring and evaluation. Data needs should be defined and systems for collection developed for all current and future activities. The plans should be specific/adequate in detail for guiding implementation/ reporting. It should be management-oriented and user-driven. Data inputs should be geared toward the minimum necessary to assure adequate decision-making effectiveness and reporting needs.

2) Medecins du Monde should improve and submit timely substantive quarterly reports to the AID/REP relating specific objectives/targets to the specific degree of accomplishment. Action plans to resolve problems should be generated in the field for concurrence/decision of the home office and included in quarterly reports. Medical teams should be required to submit written reports of their work inside at MDM facilities.

3) Data collected should have feedback loops to the field and be incorporated in subsystem decision-making processes (e.g., curriculum development, clinic staffing, etc.).

MAP F: HEALTH FACILITIES OF MEDECINS DU MONDE (MDM)
IN AFGHANISTAN
(July 1987)



*Numbers refer to Table

[redacted]

TABLE 20

Health Facilities in Afghanistan
MDM - MEDECINS DU MONDE

As of
July 1987

	Province	Area/Village	Party Affiliation
Hospital	1. Wardak	Jagutu	Mahaz
Dispensary	2. Wardak	Chak Wardak	Mahaz
	3. Ghazni	Jagutu-Ghazni	Mahaz
Mobile Unit	4. Kunar	Mared, Sokai Valley	Jamiat

[redacted]

TABLE 21

MEDECINS DU MONDE

Admission and Retention Criteria

Recruitment:	Recruited and trained "inside" Afghanistan through commander relationships. Not aligned with Alliance Peshawar.
Criteria:	
Admission:	Some knowledge of English. Working Inside
Retention:	Continue working inside. Referral for further training to FM/MTA of good students.
Instructors:	Expatriate Two Physicians
Assignment:	Assigned with French translator with supplies to specified areas. May, with further experience be assigned independently to outreach areas as first state/basic health units with referral to established units and periodic visits by physicians from referral center.
Proposal for Future:	Training of Vaccinators

TABLE 22

Proposed SUD/MDM-AVICEN Training Program
(Afghanistan Vaccination and Immunization)

Vaccinators/Vaccinator Technician Course

Subject Areas

Level I - Theory: Lecture/Discussion

- Immunology
- Vaccines and Methods of Administration
- Target Groups and Immunization Calendar
- Side Effects and Contraindications
- Cold Chain and Transportation
- Management and Systems for Immunization Programs
- Data Collection and Recordkeeping
- Basic Epidemiology

Level II - Technical Application: Demonstration/Discussion

- Technical Understanding, Use, Maintenance and Repair of Specific Equipment and Supplies

  -- Practical Experience Under Supervision in Border Camps Planned Prior to Certification
  -- Course Length - Variable
  -- Student Materials - Translated (English-French-Dari) Reference Manuals Specific to the Program to be Developed
  -- Instructors: Qualified Medical and Technical Personnel
  -- MDM or Other Organizations are Expected to Support and Utilize Graduates in MDM/Other Vaccination Projects Inside

G. Medical Training for Afghans (MTA)

1. Introduction to MTA

a. Location, General Objectives

The Medical Training for Afghans (MTA) program is a direct response to the need for intensive training of Afghan medics as perceived by Aide Medicale International (AMI), another PVO which has worked in health care delivery inside Afghanistan since 1980. AMI (with branches in both Paris, France and Liege, Belgium) and Solidarite Afghanistan/Belgium founded MTA with the explicit purpose of training in mind.

MTA training began in Fall 1985 at its 20-bed teaching hospital in Peshawar. At this facility students undertake a lengthy 16-month period of training, with both classroom work and daily practicum. In addition, MTA has a training clinic in Chitral in coordination with FM. Students also work in refugee camps at Hangu, southwest of Peshawar, and at a training site across the border in Afghanistan which is organized by AMI. There have been three small classes to date of approximately 37 students. Only one class of 11 has graduated. Six students have returned to Afghanistan and the remaining five will go inside soon (Table 23, Map G).

b. Organizational Structure and Function

(1) MTA Office in Pakistan

In Peshawar the MTA Project Manager is affiliated with Solidarite Afghanistan/Belgium, while the Medical Coordinator is affiliated with AMI. Administration of the project is excellent, with the presence of a skilled and enthused Project Manager. The medical expatriate staff from AMI includes three doctors and two nurses, which is thought by staff to be too few; they quickly become too exhausted from long hours of teaching and hospital work. Similar to MRCA, MTA will be moving to a new multi-organization complex in Hayatabad, an area of Peshawar near the Kacha Ghari refugee camp. This will be also shared with TTC (Belgium), ASYAR (Belgium) and the Sandy Gall Appeal for Afghanistan (British). MTA will build a 35-bed training hospital there along with a dormitory. Funding for this undertaking is partially obtained from ECC (European Community Commission).

(2) Relations Between Home Office(s) and Field

MTA is an exception in that it has two home offices: Solidarite Afghanistan in Liege, Belgium and AMI in Paris, France. Relations are in general favorable, although they "have their ups and downs". Letters from the field from the Project Manager are sometimes slow to be answered, such as his recent request to deal with the overcrowded staff house by renting additional quarters. No serious problems exist, however.

(3) Coordination with Afghans in Pakistan and Afghanistan

(a) Afghan Parties, Commanders and MTA

MTA has had representatives of the various political parties attend formal functions at the training hospital. Commanders nominate participants and a letter is sent to the party headquarters setting out in detail the process of formal recruitment and selection. During training the sponsoring party is expected to pay the students' pocket money (150Rs/month) although this is sometimes not received.

(b) General Framework for Service Delivery in Afghanistan

MTA's official capacity is as a training facility, and it does not have a network of its own facilities inside Afghanistan. Rather its students serve in a variety of contexts--in commander-affiliated units and in units of other PVOs such as AMI, Swedish Committee, etc. Some may also work alone. Upon leaving Peshawar each graduate receives supplies from the Swedish Committee.

To date, only six students in the first graduating class of 11 have returned to Afghanistan. A few months ago they left for the east-central provinces of Wardak (Nejat), Logar (Hezbi-Gulbuddin), and Kabul (Hezbi-Khalis) but, to date, no word has been received from them. The remaining five from more distant areas, who are all affiliated with the Jamiat party, will go inside with the AMI evaluation team of two French doctors which is planning to leave in late July.

Given the short-period of time that MTA graduates have been in Afghanistan, there is little to report about MTA-related health care in the country.

(4) Coordination Between MTA Activities in Pakistan and Afghanistan

Although MTA has just graduated its first class, it should be emphasized that this PVO is extremely interested in on-the-spot evaluation and monitoring of its returning students. This is a positive indication that it will utilize such information, when available, to improve its training efforts.

c. Coordination with Other PVOs, CMC, AID/Rep, etc.

Coordination and communication is very important to MTA. It sends its students to MRCA for specialized training and some MDM students come to MTA for training.

MTA itself was instrumental in having the AMI evaluation team come to Pakistan for its observation of health workers' activities inside Afghanistan.

It is a strong supporter of and participant in CMC, and welcomes coordinative efforts.

Reports submitted to AID/REP are few, but they are well-written and informative. Some problems in translation from French to English exist, but these are minor.

d. Recommendations

1) MTA's willingness to participate in evaluation of student activities should be fostered, perhaps with the creation by CMC of additional monitoring/evaluation teams to travel to Afghanistan in the near future.

2) More effort should be made to recruit additional technical expatriate staff to avoid "burn-out". More careful selection/screening procedures are also called for.

2. Educational Component of MTA Program/Project

a. Background

The MTA education program was established to train Afghans health care personnel inside Pakistan. MTA does not maintain facilities inside Afghanistan. Graduates are expected to work inside Afghanistan as "assistant doctors" at facilities established by other PVOs/organizations (MDM, Swedish Committee). The original education proposal envisioned an 18-month program and graduated its first class of 11 in March 1987. Of these 11, six have returned inside with various commanders to the north. Five are awaiting transport and logistics arrangements and are expected to return before fall.

The second and current class of 11 will complete their studies within 16 months (September 1987) and an overlapping third class of 15 will graduate in October or November. The numbers of students accepted and successfully completing each program has remained approximately the same with an average dropout rate of three students per each group.

All course didactics are presented in French with the use of two Afghan translators who have professional backgrounds (one Afghan physician and one former agricultural minister) and are also fluent in French.

Students are offered the opportunity to further increase their skills following completion of this course through the specialty areas of MRCA. However, all students are expected to return inside for a period of six months to one year prior to undertaking any additional education offerings after MTA "graduation".

b. Facilities

Teaching and Service

The current MTA facilities include classroom, dormitory, small tent OPD and hospital, as well as administrative offices. Further facilities are being constructed as part of a training and service complex in coordination with MRCA and two other organizations (French and British--non-health teaching). The OPD provides service to approximately 20 patients per day for Afghans within the Peshawar area. A screening and number system is used to determine patients seen. Advanced students staff the OPD independently and seek guidance when necessary from the expatriate physician on duty in the adjacent hospital. The 20-bed hospital and emergency room provide emergency and in-patient care to those referred through the OPD. Primary form of service is medical in nature with limited surgical services (referred to MRCA).

Students work one-on-one, or one-to-two with expatriate physicians/ nurses. In addition to the MTA teaching/service facilities, students rotate for further experience to the Chitral clinic and some limited experience in nearby camps.

c. Course Admission Criteria and System

Students are recruited by letters sent to various commanders through the parties. Table 24 outlines admission criteria. An acceptance letter is returned to commanders following student selection. Commanders are expected to pay students a stipend of Rs 150 per month (pocket money) throughout their training period. Some difficulties have occurred from time to time due to lack of payment to students. Retention is predicated upon successful completion of the first month training in first-aid and students must successfully complete both an oral and written exam to remain in the program. Thereafter, periodic evaluations and exams every three weeks are conducted throughout the remainder of the course and at the conclusion of training. Examinations are both written and practical and daily discussions with the supervising physicians/nurses are conducted on specific cases seen in the OPD or on hospital rounds.

d. Curriculum and Methodology

The current curriculum of MTA has evolved from experience gained with the first group of students. The course has been decreased in length from 18 to 16 months and practical experience given a greater focus.

The current format includes approximately two and one-half hours of daily formal information lecture/discussion presentations followed by four hours of experience in the OPD or Hospital. Chitral clinic rotation is intended to provide field setting experiences to build confidence and skills.

Independent and student group study is encouraged between "upperclass" students and beginning class groups (teach each other).

Translated lecture materials and the GAC Pharmacology manual are the primary references used.

Due to the small number of patients seen on a daily basis, students are afforded an opportunity to learn diagnostic techniques and integrate knowledge with practice. However, this limited "pool" of patients also restricts the variety and number of situations each student is exposed to.

Some consideration for expanding the number and type of teaching patients should be considered. (Increase OPD numbers, expand opportunities for rotations in other settings, increase activities in camps, etc.)

The subject areas covered are listed in Table 25. While appropriate in subject, no content breakout is available to determine level of detail being taught or specific skills/procedures being learned. However, from question responses, the MTA graduate is similar in skills and knowledge to other PVO-trained "medics" with a very limited surgical focus.

Some consideration should be given to the need for increased emphasis on community health subjects and field health management problems such as drug and supply management, site selection and water and sanitation problems and solutions. Additional information such as medical ethics and humanitarian principles for health workers could also be incorporated. The knowledge and basic skills for management of dental emergencies could be incorporated in a course of this length through cooperative arrangements with other PVOs (MRCA) similar to the current cooperative surgical experience. The 16-month time frame should allow MTA to broaden its curriculum scope and still maintain quality students. The current curriculum is not overly ambitious for a 16 to 18-month duration and small number of students per class.

e. Educational Administration and Faculty

The responsibility for administration of the program rests with an expatriate project director with assistance from a medical coordinator. Faculty are expatriate physicians and nurses recruited by the "home office" for varying lengths of time from six months to one and one-half years. Currently, this staff consists of three physicians and two nurses. These expatriates are volunteers who do not receive salaries. Frequently, they are younger health professionals with limited teaching experience.

Expatriate staff have an orientation/overlap period with outgoing instructors prior to assuming teaching roles. This provides them an opportunity to observe teaching methods and subject areas being covered for continuity of subject and level of detail to be taught.

While some Afghan health personnel are part of the staff, they do not assume teaching roles (translators). It is felt that potential difficulties could occur related to student/teacher relationships and authorities as well as differences in medical opinions/practice standards, which would confuse or dilute students learning objectives.

Two Afghan professionals provide translation services for classroom situations (Farsi). Both are French-speaking and materials for students have been translated for student use.

f. Educational Program Recommendations

1) This course appears to be excessively long for the amount of subject matter/areas covered and the limited number of students. MTA should carefully reevaluate the need for this time period in view of only the essential level of detail required, methods of instruction and actual skills to be learned. MTA courses appear to be of no greater level of information/skills for mid-level health workers than those of six to eight-month duration. MTA should either shorten the course considerably or develop additional skills and subject areas for inclusion which upgrade MTA graduates beyond the other mid-level curriculum of six-eight month courses. With all due deference to differences in teaching methods and philosophies, this course is too long, not enough substance in either theory or practice and trains too few.

2) Identify, develop and implement specific skills list system to monitor each individual student's performance, completion and level of achievement.

3) Develop curriculum material to include all subject matter at appropriate level of detail for the students.

4) Utilize developed curriculum to assure instruction control within and between courses/classes (future instructors should teach same materials and level of theory as the last; six-month rotation of expatriate staff equals three sets of instructors per course).

5) Develop specific job descriptions for instructors/trainers.

6) Strengthen practical focus of program and increase student opportunities to develop skills in addition to limited OPD diagnostic/history-taking (other settings, more patients, field excercises, etc.).

7) Enhance visual and practical teaching tools (i.e., oversized anatomical charts, slides, model demonstration sessions, etc.).

3. Monitoring and Evaluation

a. Overview

MTA has submitted an annual report for FY 1985-1986 and anticipates submitting the FY 1986-1987 report shortly (not available for review). The 1985-1986 report reflects historical information and narrative information on progress made, problems and solutions and statistical data. However, MTA should consider reformating reports to reflect specific objectives for the specific period and progress achieved toward them. Evaluation mechanisms are implied by reference to decisions made related to overall project modifications and structure changes.

b. Training

The MTA proposal references continual assessment of students and thorough examination at the end of each session (three six-month sessions). The one-to-one instructor/student ratio affords continuous informal evaluation and presumably feedback to the student. However, formal systems or records of such activity should be considered for development/tracking.

c. Clinics

MTA is a training "institution" and does not establish/maintain service facilities within Afghanistan. The OPD and Hospital serve as training sites for students while providing limited service to Afghans within the local community. The OPD provides service to approximately 20 patients per day and the Hospital has 20-21 bed capacity for medical or convalescent surgical patients from other hospitals. No surgery is performed within the Hospital except minor procedures.

d. Staff

The Hospital/medical nursing staff are all expatriates, with Afghan personnel as translators/support personnel (cooks, drivers, housekeepers, etc.). Expatriate staff are recruited and assigned by the home office. Usual duration of assignment is six months. Formal recruitment systems are unclear to the team between the three involved organizations. No formal staff evaluations are kept in the field. Informal evaluation occurs between the senior medical staff and other medical personnel as well as with the project administrator.

e. Recommendations

1) MTA should develop an overall strategy for monitoring and evaluation. It should be management-oriented, user-driven and geared toward the "minimum" necessary.

2) Data collected from MTA graduates in Afghanistan should be reviewed annually to determine utility of course content. Subsequent modifications of course content/curriculum should be made on this basis.

3) Education data, analysis and use should be maintained in the field and instructor input communicated to the home office.

MAP G: APPROXIMATE LOCATIONS OF MEDICAL TRAINING FOR AFGHANS (MTA) TRAINING COURSE GRADUATES IN AFGHANISTAN (July 1987)

*NOTE: Exact locations and health facility types are indefinite.

*Numbers refer to Table

[redacted]

TABLE 23

Graduated Students Now in Afghanistan* as of
MTA - MEDICAL TRAINING FOR AFGHANS July 1987

	PROVINCE	AREA/VILLAGE/TOWN	PARTY AFFILIATION
1.	WARDAK	Jagatu	Nejat
2.	WARDAK	Jagatu	Nejat
3.	LOGAR	Bargibark	Hezb
4.	LOGAR	Bargibark	Hezb (Gulbuddin)
5.	KABUL	Paghman	Hezb (Khalis)
6.	KABUL	Paghman	Hezb (Khalis)
7.	MAZAR-I-SHARIF	Sholgara	Jamiat
8.	HERAT	----	Jamiat
9.	BADAKHSHAN	----	Jamiat
10.	TAKHAR	Farkhar	Jamiat
11.	PARWAN	Panjsher	Jamiat

*Type of health facility indefinite; location somewhat indefinite (home of student). (see map.)

[redacted]

TABLE 24

MEDICAL TRAINING FOR AFGHANS

Admission and Retention Criteria

Recruitement: Letters of approval from commanders and Alliance commanders pay students Rs 50/mo while in course..

Criteria:

Admission:
- -Written examination.
- -12 grade/equivalent minimum education requirement.
- -Geographical consideration.
- -Have not been out of Afghanistan for more than 3 months.
- -Interview by selection committee/personnel.

Retention:
- -Must pass 1st month First Aid Course - Written and oral examination.
- -Examinations every 3 weeks and practical evaluations during course.
- -Final examination.

Current Instructors:

Ex-Patriot: 3 Physicians
2 Nurses

Afghan: 1 Physican Translator
2 Translators

TABLE 25

MEDICAL TRAINING FOR AFGHANS

MTA - Course Structure - Certification and Assignment Specifics

Course: MEDICAL TRAINING - 16-18 Month

Subject Areas*	Approximate Hours of Instruction	Methodology	Students Materials/References
First Aid Hygiene Anatomy and Physiology Pharmacology Nursing Care Signs and Symptoms Pathology -Pediatrics -Infections Diseases -Pulmonary Diseases -Digestion Diseases -Cardiovascular -Urology -Dermatology -Opthomology -ENT Gynecology/Obstetrics Emergency Situations Public Health Anesthesia	1 Month	Lecture/ Demonstration 2 1/2 hours class/day 6 days/week Practical Experience in OPD & Hospital Plus Critical Clinic Rotations 4 hours/days 6 days/week	Translated lecture materials and GAC pharmacology text.
Surgegy	1 Month		MRCA hospital experience

* Program Outline on file AID/REP Office, Islamabad

Certification: -Students are called "Assistant Doctors"
-Are accepted for further surgical experience or other specialty areas of MRCA after have "inside" working experience.

Assignment: -Assigned to clinics of other PVO's, (MDM) or establish new ones.
-Are paid following 3 months service inside.

APPENDIX

Appendix A

Statement of Work

Background

The Office of the A.I.D. Representative presently finances seven private voluntary organizations (PVOs) that run medical training programs for first-aiders, pharmacists and/or medics. Medical Training for Afghans (MTA), Medical Refresher Course for Afghans (MRCA), Medecins du Monde (MDM), Freedom Medicine (FM), International Medical Corps (IMC), German Afghanistan Committee (GAC) and Mercy Corps International (MCI).

Most of these PVOs also support medical facilities inside Afghanistan. Working with various commanders and parties, they determine where clinic facilities should be established and then send trained students and other higher-trained personnel to provide health care. Most of the PVOs maintain 10-20 bed facilities to complement their programs. Currently, however, there is no standardized training approach nor standardized curriculum. The duration of the courses (six to sixteen months) varies enormously.

The various organizations generally recognize the need for an effective trainee selection process, core curriculum, follow-up and continuing education. This is most evident in the discussions emanating from the Committee of Medical Committees (CMC), which they have formed for coordination purposes. Most medical groups working inside Afghanistan supply drugs and equipment to their clinics, and almost all have begun to standardize their medical supplies based upon the positive list of the Swedish Afghanistan Committee, an eighth PVO involved in medical logistics support to the Afghans. Nonetheless, there are still differences among the groups in type of drugs used, dosage and, sometimes, treatment. In April 1986, the AID/REP sent letters to each health PVO specifying the types of information that should be collected and submitted to A.I.D. on a quarterly basis.

Objective

1. Examine each PVO's total program as presented in the grant proposals to determine if they have met their objectives;

2. Recommend ways in which each program can be strengthened; and

3. Determine the best moethods to gain agreement among PVOs in training (selection, curriculum and examination), proper medical supplies, monitoring, salary payment and site locations of facilities.

Scope of Work

(This scope of work includes questions that the entire team will be responsible for addressing. The individual contracted through this IQC will act as the medical training expert on the team and will, therefore, be responsible for answering those questions and preparing those sections of the report that require medical training expertise. The other two team members are: an A.I.D. Evaluation Officer and an antropologist that is being contracted through a PSC by the AID/REP.)

1. Project Effectiveness

a. Are the PVOs making timely progress toward the achievement of their objectives? To what extent? For each PVO and type of worker trained: How many individuals have been trained? What percentage of trainees have returned to work inside Afghanistan and what is the average length of stay? To what extent has the training proven effective and appropriate for the conditions and problems encountered inside Afghanistan? What changes have the PVOs made to make their training more responsive? What training gaps have been identified?

b. What areas need strengthening or changing? Were these needs identified by the PVO? What actions are being taken?

c. Does the PVO have a system to identify problems? Does it take corrective action?

d. How and to what extent does each PVO program fit into AID/REP's health sector strategy? Do the PVO programs conflict in any way with AID's objectives? If so, how?

e. What steps can PVOs and AID/REP take to overcome any weaknesses that are impeding PVO effectiveness? What options are available for strengthening or directing the PVOs?

f. What changes are needed in the curriculum, content and methods of training to increase effectiveness?

g. At this point, where do the major training gaps/shortages exist? Which, if any, of the PVOs could effectively expand its capacity to train more workers?

2. PVO Compliance with Monitoring and Evaluation Guidance and Reporting of Outcomes

a. To what extent have the PVOs complied with their original grant plans for monitoring and evaluation?

-- Have the PVOs made plans for collecting data? If so, are they described somehwere or can they be described verbally?

-- Have the PVOs begun to collect data specified in the guidance provided by AID/REP? Have they decided on alternative indicators?

-- To what extent do the data collected (or planned to be collected) reflect performance and effectiveness and go beyond input/output?

-- To what extent do the data represent valid evidence of progress made toward the achievement of objectives?

-- How often is the AID/REP receiving data? Is data submitted with regularity? Is the reporting adequate?

b. To what extent are the PVOs using the data for problem-solving and making informed decisions? What programmatic decisions have been made (e.g., changes in activities, types of activities) based on the data?

c. To what extent do the PVOs have the skills and interest for collecting and utilizing performance data to improve the quality of their programs in order to demonstrate effectiveness?

3. Guidance

a. To what extent does GOP policy affect PVO implementation?

b. Are PVO programs cost-effective, taking into consideration the exigencies of the war? To what extent are the PVOs dependent upon A.I.D. financing? What action, if any, should we take in this regard?

c. Should we seek changes in any/all PVO programs to better meet A.I.D. objectives? Is it feasible to try?

d. What steps should PVOs take to improve their monitoring and evaluation systems and the reporting and utilization of their data?

e. What actions should we take to assist PVOs in improving their monitoring and evaluation systems and the reporting and utilization of their data, given constraints of current staff and workload?

4. PVO Collaboration and Coordination to Achieve Objectives

a. To what extent have the PVOs collaborated in identifying areas that need strengthening and take needed actions; for example, standardizing salary payments to medics, coordinating medical supply lines and approving a core training curriculum?

b. What specific steps should the PVOs take and in what areas should they focus their efforts?

c. What actions should we take to assist the PVOs in standardizing medical programs?

Reporting Requirements

a. Format of the Report: The final report shall contain, at a minimum, the following sections:

-- Basic Project Identification Data Sheet

-- Executive Summary (of not more than three single-spaced pages, prepared according to Evaluation Summary instructions.

-- Body of the Report shall include: a brief description of the project context (background and purpose of the AID/REP PVO Co-Financing Project); description of each individual PVO project (including planned targets and strategy for achieving targets); findings, conclusions and recommendations that specifically answer the questions raised in the Statement of Work.

-- Appendices - These should include, at a minimum:

- -- Evaluation Scope of Work
- -- Description of the Evaluation Methodology
- -- Findings/Conclusions/Recommendations Matrix
- -- Bibliography of Documents Consulted
- -- Evaluation Summary

b. Submission of Report: The evaluation team shall prepare a draft final report and provide a copy to the AID/REP at least four days prior to departure from Pakistan. The evaluation team shall be prepared to provide a short oral presentation of the team's findings and recommendations to the AID/REP prior to departure. Prior to leaving Pakistan, the evaluation team will incorporate initial comments from the AID/REP into the draft final report.

Appendix B

LIST OF INDIVIDUALS CONTACTED

1. Office of AID/REP, US Embassy, Islamabad

Carole Scherrer-Palma	Special Projects Officer/Health
John Gunning	Program Officer

2. Mercy Corps Interational (MCI), Quetta

Jerry Dines	Country Director
Andrew Wilder	Administrative Coordinator
Engineer Ayubi	Medical Training Director
Farouq Fermand	Inside Projects Officer
Nancy-Jo Hoover	Laboratory Technician
Tom Nygren	New Administrative Coordinator
Janet Nygren	Administrative Assistant
Helen Murray	Nurse/Administrator
Fazal Din	Practical Training Coordinator
Dr. Parkash	Instructor
Halima Thomas	Instructor
Students	

3. Office of AID/REP, US Consulate, Peshawar

Albert Nehoda	Personal Services Contractor

4. International Medcal Corps (IMC), Peshawar

Jeff Paulsen	Director of Operations
M. Nasir	In-Country Director
Dr. Tom Kress	Medical Director
Hoveida Saad	Director of Recruiting (Home Office)
Dr. Quadrat	Instructor
Students	

5. Freedom Medicine (FM), Peshawar, Thal

Gaye Brenner	Project Director
Bob Brenner	Field Director
Dr. Pam Johnson	Medical Director
Dr. Hashim	Hospital Director
Dr. Noori	Instructor
Rich	Paramedic
Isabel Hemming	Nurse
Melba	Nurse
Students	

6. German Afghanistan Committee (GAC), Peshawar, Sadda

Ibrahim Rashid	Director
Michael Sagurna	Representative, Bonn Committee
Dr. W. Eros	German Doctor
Dr. Zafar	Director of Inside Operations
M. Sadiq Iqbal	Training Director
Dr. Haiatullah	Physician/Instructor
Dr. Faridullah	Physician/Instructor

7. Medical Refresher Course for Afghans (MRCA), Peshawar

Arielle Calmejane	Director
Expatriate Dentist	
Expatriate Surgeon	
Expatriate Physical Therapist	
Afghan Physical Therapy Assistant	
Students	

8. Medecins du Monde (MDM), Peshawar

Dr. Xavier de la Cochetiere	Director
Dr. Christian Courtade	French Doctor

9. Medical Training for Afghans (MTA), Peshawar

Michel Tonneau	Project Manager
Expatriate Physician	
Youssef Jamshed	Assistant Director

10. Aide Medicale Internationale (AMI Evaluation Team), Peshawar

Dr. Thierry Barbe
Dr. Giles Benard

11. Coordination of Medical Committee (CMC), Peshawar

Dr. John McGill	Medical Director
Anke Lerch	Administrative Director

12. Swedish Committee for Afghanistan (SCA), Peshawar

Anders Fange	Representative
Dr. Haider	Medical Director

13. International Rescue Committee (IRC), Peshawar

Tom Yates	Director
Stephen Siegal	Deputy Director
Stephanie Foster	Director of Health Education Resource Center

14. Management Sciences for Health (MSH), Peshawar

Dr. William Oldham	Team Leader
Anibal Mejia	Senior Management Advisor
Dick Johnson	Training Advisor
Dr. Laurance Laumonier	Medical and Field Operations Advisor

Appendix C

GLOSSARY

Cold Chain	Continuous refrigeration of vaccine from development (manufacture) to delivery (innoculation)
Green Books	Medical patient record books kept by health care workers in facilities within Afghanistan.
Log Books	Patient record books kept by health care workers at Afghanistan facilities.
Mujahiddin	Afghan resistance, freedom-fighters.
Rupee	Pakistan's unit of currency--US $1.00 equals approximately Rupees (Rs) 17.5.
Tanzim	Afghan political party.
Yellow Books	Surgical patient record books kept by health care workers in facilities within Afghanistan.

Appendix D

LIST OF ACRONYMNS AND ABBREVIATIONS

AID	Agency for International Development
AID/REP	Office of the A.I.D. Representative
AMI	Aide Medicale International
BCG	Live Anti-Tuberculosis Vaccine
CMC	Coordination of Medical Committees
DPT	Diphtheria, Pertusis and Tetanus Vaccine
DRA	Democratic Republic of Afghanistan
EX-PAT	Expatriate
ECC	European Community Commission
FA	First Aid
FM	Freedom Medicine
GAC	German Afghanistan Committee
ICRC	International Committee of the Red Cross
IMC	International Medical Corps
IRC	International Rescue Committee
LAB	Laboratory
MCI	Mercy Corps International
MDM	Medecins du Monde
MRCA	Medical Refresher Course for Afghans
MSF	Medecins Sans Frontieres
MSH	Management Sciences for Health
MTA	Medical Training for Afghans
N/A	Not Applicable
NCA	Norwegian Afghanistan Committee
NWFP	Northwest Frontier Province
OPD	Outpatient Department (Clinic)
PAK	Pakistan
SCA	Swedish Afghanistan Committee
TRG	Training
(#)o	Hours

Appendix E

THE ALLIANCE

(MAJOR AFGHAN POLITICAL PARTIES/LEADERS BASED IN PESHAWAR)

	Name	Name
1.	MAHAZ-I-MILLI ISLAMI (National Islamic Front)	SYED AHMAD GAILANI
2.	JABHA-NAJAT-I-MILLI AFGHANISTAN (National Liberation Front	SEBHATULLAH MUJADIDI
3.	HARAKAT-I-ISLAMIC	MAULAVI MOHAMMAD NABI MOHAMMEDI
4.	HEZBI-I-ISLAMI	MAWLAWI MOHAMMAD YONUS KHALIS
5.	HEZBI-I-ISLAMI	GULBUDDIN HIKMATYAR
6.	ETEHAD-Islami	PROF. RASOOL SAYYAF
7.	JAMIAT-I-Islami Afghanistan	PROF. BURHANUDDIN RABBANI

The popular party name is underlined here; in this report leaders names are used with reference to the parties.

Appendix F

AMI EVALUATION FORMAT TO ASSESS STUDENTS INSIDE AFGHANISTAN

Introduction

Some questions must be asked to present the student's place. As far as there is a medical interest in it, the answers should be completed. But this chapter is not written by war specialists nor by agronomists so it is not necessary to try to get an extensive point of view. Many difficulties in collecting some of this information are expected.

What is the student's name?
Where does he work?
Name of Area, Province, District, Valley, Village
What are his party affiliations?
What is the district commander's name?
What other parties are in the area?
Name of Parties, Commanders
What is the military situation?
At time of survey?
During last year?
Frequency of bombing and attacks?
What is the civilian situation?
Exodus rate?
Schools?
Food availability?
Prices of a kilo of sugar, tea, rice, cooking oil, wheat flour?
Prices of the same foods last year?
Agricultural status?
How many houses (families) does he take care of?

Integration in the Community

This chapter concerns points which were not taught. It takes the local problems into account and gives us the limits of what could be expected from the student's work. A good integration in the community is essential to each student's work.

Does he work in the area from where he comes?
Does he work in the area where he expected to when leaving Peshawar?
If not, why?
How long has he been working there?
Does he live in the clinic?
Does he work alone?
If no, who is working with him?
Does he visit some patients at their homes?

Does he go with the mujahiddin to the battle front?
Does he look after women?
Does he look after children?
Does he look after people from other parties?
What are the percentages of these patients?
How many patients does he see in one day?
How many patients did he see in the past three months?
How far do the patients have to walk to reach the clinic?
What are the business hours?
Who built the clinic?
How long did it take?
When was it done?
Who decided the site of the clinic?
What sort of relationship does he have with his district commander?
What sort of relationship does he have with his party?
How far is the nearest other medical facility?
Who is working there?
Where have they been trained?
What kind of equipment is located there?
Do they always have medicines?
Is it open all year?
Are there other medical personnel in the area?
Where are they?
Do the students have personal or professional relationships with them?
Did he form connections with the traditional medics?
Is the student in contact with the health committee of his district?
Does he have contact with all the population?
Does he receive a salary?
Are the patients charged for consultation?
How much is it?
Are the patients charged for their medicines?
Where are the medicines coming from? Who supplies?
What are the medicines locally available?
Are Afghan patients going to local pharmacies with prescriptions?
Who provided the staff of the clinic?
Who pays them?
Is there any new pharmacy set up these last months?
Is there any new chaikhana set up these last months?
Are there anti-aircraft defenses near the clinic?
Did the student try to inform and teach the population?
What seemed to be the results?

Equipment

a. Building

Is it clean?
What does he do with the rubbish?
Has he got an examination table?

Has he got a waiting room?
Has he got in-patient beds?
Who built them?
How is the light? The heating?
Is it well ordered? Well organized?
Is there water in the clinic?
If not, where is the nearest water and how long does it take to get it?

b. Surgical Instruments

What are they
Are they clean?
Are they sterilized and how?
Are they well ordered?

c. Medicines

Does he know what he has in stock?
Does he use his register book?
Is the register book kept up to date?
Has he got some medicines he is not supposed to use?
How does he get his supplies?
Did he run out of his stock of medicine?
If so, what did he do?
How are the medicines stored?
Which medicines does he not use?
Which medicines are lacking?
Does he pay attention to pre-emption and fabrication dates of medicines?
Have medicines been lost in transit? When and How?
How often are medicines sent to the clinic?
What are the five medicines he uses the most?
When is the next shipment expected?
What medicine is lacking the most? More often?

d. Documents

Does he take pictures?
Has he reference books? Which ones? Does he use them?
If not, does he use only the courses?
Does he take notes?
Are there medical problems he could not solve he wrote down so he could get the answers later?
Does he give a health paper to mothers of children?
Does he keep medical records?
What information is recorded?
Are the medical records kept up to date?
What was the last date of entry?
Are the medical records transmitted?
To whom?
Has he kept a record of the problems he has encountered?

Medical Practice

The questionnaire we established is divided into four groups of questions concerning:

- General Problems of Medical Practice
- Surgical Practice
- Evacuation Procedure

This is the most important part of our work because through the students' survey we are reaching the trainees and their ability to reach their goals.

We have to take the next points into account as we define the goals of the study.

- This part depends on the teaching program. The program will be considered when we write the questionnaire.

- If the information about equipment and community are not collected first, nothing will be understood.

- The theoretical examination was already done at school and we will not repeat it.

- The distribution of diseases per region, age and sex is supposed to be known through the information collected by the Swedish Committee and the medical teams.

Technically, all the pathological problems will not be evaluated. We shall focus our interest on some important points we have selected. The answers to these questions will be collected through different ways.

- We are going to work for awhile (four to seven days) with him.
- We are going to ask him about the problems he met in his past, particularly the surgical and evacuation problems.
- It seems to us that if would be unfriendly and damaging to play the role of examiner that we are not.

a. General Problems of Medical Practice

What has the student done when he met:

- a man with abdominal pain?
- a man with respiratory complaints?
- a man with musculoskeletal pain?
- a sick child?

The clinical questionning:

- Was is appropriate?
- Did it cover history of illness, other diseases and family illnesses?

The clinical examination:

- Was it appropriate?
- Did it included temperature? Hydration? Pallor? Weight? Breathing? Heartbeat? Eyes? Skin? Abdomen? Ears, Nose and Throat?

Does he arrive at a diagnosis?
Was the assessment appropriate?
What are the therapeutic decisions?

- Advices?
- Number of Medicines: Usually 2
  Usually 2
- Duration of Treatment: 5 Days
  5 Days

Nursing

- Handwashing
- Injections: Asepsis
  Quality
- Wound Dressing: Asepsis

b. Surgical Practice

Anesthesia	General	
	Local	
	Spinal	
	Drugs	
	Justified	
Abcess	Anesthesia	
	Incision	
	Antibiotics	
Burns	Dressing	
	Cleaning	
	Frequency of Renewing	
Wounds	Cleaning	
	Antiseptic Used	
Bone Fractures	Compound Fractures:	Antibiotics
		Dressing
Abdominal Wounds	Dressing	
	Antibiotics	
	Gastric Aspiration	
	Perfusion	

Approximate number of the different surgical diseases, war-relate or not.

c. Non-Surgical Pathology

What has he done when he was examining:

a child with diarrhoea?
a febrile child?
a malnourished child?
a child with measles?
a man with ascaris?
a man with pulmonary tuberculosis?
a man with malaria?
a man with renal colic?
a man with knee pain?
a man with meningitis?
a woman with post-partum bleeding?
a woman with post-partum fever?

d. Evacuation Procedure

How many patients were transported to other clinics? Where?
How many patients were sent to Pakistan?
How long did it take to reach these clinics? Pakistan?
How were they transported?
Who accompanied the patients?
What was their pathology? Injuries?
What type of medical care was necessary during transportation?
Who was responsible for this medical care?
What kind of training does this person have?
Are there referral documents?

Department of State

INCOMING TELEGRAM

PAGE 01 ISLAMA 24394 240540Z 9252 069593 AID1439
ACTION AID-00

ACTION OFFICE FPA-02
INFO ANDP-03 AMAD-01 FM-02 RELO-01 ANSA-03 /012 A0

INFO LOG-00 COPY-01 /001 W
----------031521 240559Z /12

P 240539Z NOV 87
FM AMEMBASSY ISLAMABAD
TO SECSTATE WASHDC PRIORITY 5038

UNCLAS ISLAMABAD 24394

ADM AID

FOR M/FM/PAFD/BPC FROM USAID CONTROLLER

E.O. 12356: N/A
SUBJECT: ELECTRONIC FUNDS TRANSFER

1. REQUEST FOR ADVANCE AS PER GRANT HAS BEEN REVIEWED AND ADMINISTRATIVELY APPROVED BY USAID PROJECT OFFICER.

2. PLEASE EFFECT PAYMENT VIA EFT .

A. PAYEE INFORMATION

- (1) PAYEE NAME : INTERNATIONAL MEDICAL CORPS
- (2) BANK NAME : BANK OF AMERICA NATIONAL TRUST
- - AND SAVINGS ASSOCIATES
- (3) BANK ADDRESS : WESTWOOD VILLAGE BRANCH,
- 1101 WESTWOOD BLVD.
- - LOS ANGELES, CA 90024
- (4) ABA CODE : 121000358
- (5) PAYEE'S ACCT NO. : 00993-21710
- (6) DUE DATE : 11/30/87

B. FISCAL DATA

- (1) APPROP. NO. : 72-1171021
- (2) BUDGET PLAN CODE: QDPA-87-27306-KG-13
- (3) OBLIGATION NO. : GRANT#306-0201-G-00-7200-00
- - : PIO/T#306-0201-3-70011
- (4) AMT. OF PAYMENT : U.S. DOLS. 203,965.00 (DOLLARS
- - : TWO HUNDRED THREE THOUSAND
- - NINE HUNDRED SIXTYFIVE
- - : AND 00/100).

3. CERTIFICATION STATEMENT: I CERTIFY THIS PAYMENT IS CORRECT AND PROPER FOR PAYMENT AS REQUESTED.
A. DEAN PRATT (ACO). RAPHEL

Department of State

INCOMING TELEGRAM

PAGE 01 ISLAMA 24394 240540Z 9252 069593 AID1439
ACTION AID-00

ACTION OFFICE FPA-02
INFO ANDP-03 AMAD-01 FM-02 RELO-01 ANSA-03 /012 A0

INFO LOG-00 COPY-01 /001 W
----------031521 240559Z /12

P 240539Z NOV 87
FM AMEMBASSY ISLAMABAD
TO SECSTATE WASHDC PRIORITY 5038

UNCLAS ISLAMABAD 24394

ADM AID

FOR M/FM/PAFD/BPC FROM USAID CONTROLLER

E.O. 12356: N/A
SUBJECT: ELECTRONIC FUNDS TRANSFER

1. REQUEST FOR ADVANCE AS PER GRANT HAS BEEN REVIEWED AND ADMINISTRATIVELY APPROVED BY USAID PROJECT OFFICER.

2. PLEASE EFFECT PAYMENT VIA EFT .

A. PAYEE INFORMATION

- (1) PAYEE NAME : INTERNATIONAL MEDICAL CORPS
- (2) BANK NAME : BANK OF AMERICA NATIONAL TRUST
- - AND SAVINGS ASSOCIATES
- (3) BANK ADDRESS : WESTWOOD VILLAGE BRANCH,
- 1101 WESTWOOD BLVD.
- . - LOS ANGELES, CA 90024
- (4) ABA CODE : 121000358
- (5) PAYEE'S ACCT NO. : 00993-21710
- (6) DUE DATE : 11/30/87

B. FISCAL DATA

- (1) APPROP. NO. : 72-1171021
- (2) BUDGET PLAN CODE: QDPA-87-27306-KG-13
- (3) OBLIGATION NO. : GRANT#306-0201-G-00-7200-00
- - : PIO/T#306-0201-3-70011
- (4) AMT. OF PAYMENT : U.S. DOLS. 203,965.00 (DOLLARS
- - : TWO HUNDRED THREE THOUSAND
- - NINE HUNDRED SIXTYFIVE
- - : AND 00/100).

3. CERTIFICATION STATEMENT: I CERTIFY THIS PAYMENT IS CORRECT AND PROPER FOR PAYMENT AS REQUESTED.
A. DEAN PRATT (ACO). RAPHEL