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In Depth Evaluation
of the Basic Health
Services Project

(Project No. 306-0144)

A.I.D.
Reference Center
Room 1658 NS

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GLOSSARY

| | |
|--------------|--|
| GOA | Government of Afghanistan |
| MOPH | Ministry of Public Health of GOA |
| BHS | Basic Health Services |
| BHC | Basic Health Center |
| AHDS | Alternative Health Delivery System |
| VHW | Village Health Worker |
| ANM | Auxiliary Nurse Midwife |
| Dal | Traditional Birth Attendant |
| AFGA | Afghan Family Guidance Association |
| FP | Family Planning |
| MCH | Maternal and Child Health |
| PHO | Provincial Health Officer |
| RHO | Regional Health Officer |
| USAID | United States Agency for International Development |
| AID/W | USAID Headquarters in Washington |
| CDE | Capital Development and Engineering Office of USAID |
| RD | Rural Development Office of USAID |
| MSH | Management Sciences for Health (Cambridge, Mass.) |
| UCSC | University of California, Santa Cruz |
| WFP | World Food Program |
| PP | Project Paper |
| ProAg | Project Agreement |
| LOU | Letter of Understanding |
| PL | Project Implementation Letter |
| PAR | Project Appraisal Report |
| FAR | Fixed Amount Reimbursement |
| KAP | Knowledge, Attitude, Practice |
| ABS | Annual Budget Submission |

I. Introduction

The Basic Health Services Project, jointly agreed to by the Ministry of Public Health (MOPH) and USAID, was designed to achieve two purposes:

a) to provide access to Basic Health Services (BHS), with emphasis on services for women and children, to 830,000 persons living in 50 Minor Civil Divisions within four of Afghanistan's six health regions; and

b) to develop elements of two or more alternative Health Delivery Systems (AHDS), that are demonstrably effective, replicable and feasible financially and administratively, in providing a minimal health service for those persons who will not have reasonable access to a Basic Health Center (BHC).

Recognizing that the project has been underway for barely a year, this evaluation has set out to accomplish two tasks:

a) to assess the current progress in meeting the stated objectives of the project and to make recommendations where appropriate for accelerating project performance; and

b) to describe the present status of various project activities, targets and assumptions to serve as a baseline for evaluating the project in coming years.

This evaluation is premised on the conviction that actual provision of improved and expanded health services, especially for women and children, is the critical variable for project success and that construction of facilities is merely a means to this end.

The main body of this report addresses the first task and is intended to be decision-oriented. It does not dwell on a description of project failings. Rather it seeks to diagnose the major problems and call attention to issues which may affect project implementation and success. The specific recommendations offered for dealing with these problems and issues may or may not be accepted by the responsible management authorities of both parties. That is their prerogative and decision. The evaluation aims only to fulfill its responsibility for presenting clear options for decision-making. Accordingly, it has opted for candor over rhetoric. The Evaluation Team trusts this report will be read in this spirit.

Annex D addresses the second task and is intended to provide the project staff with a detailed project status measured against the logical framework, where appropriate unrealistic targets and assumptions have been identified. Some revision in the logical framework will be needed before the next evaluation.

There remains only to thank all the participants in this evaluation for their time and thoughts on how this project can achieve its aims more rapidly.

II. Overall Assessment

The first year's progress toward meeting project objectives is encouraging. The project design requires revision of certain objectives and assumptions. For example, the evaluation concludes that the provision of maternal child health and other basic health services in the Ministry's existing 106 rural Basic Health Centers (BHCs), where a full range of basic health services were not previously available, is equally important as the expansion of basic health services through construction of 50 new centers. This is particularly so, in the early stages of the project while construction delays are being ironed out and local female workers are recruited and trained. MOPH and USAID project staff have in fact recognized this and channelled efforts to upgrading the existing BHCs. Establishment of temporary quarters, though as yet not fully operative, also offers a good way of accelerating the expansion of basic health service delivery, while construction of new centers is underway; provided new staff and resources are added to the BHC system and not simply transferred from existing BHCs to newly established temporary BHCs.

During the six months preceding this evaluation a major disagreement had developed between the parties to the project over funding contributions, reasonable cost estimates, and a realistic construction schedule which tended to overshadow the broader aspects of the project and threatened to jeopardize good working relationships. This problem has now largely been resolved.

III. Methodology

A. Introduction

The methodology for this evaluation was formulated by Development Alternatives, Inc. (DAI) under a contract with AID in February 1977. DAI recognized the measurement problems posed by undertaking this evaluation after only one year of project implementation. Consequently, it suggested the evaluation focus less on measuring actual achievement against planned objectives and more on assessment of the objectives and establishment of a framework for more in-depth analysis after the second year.

The Evaluation Team, constituted in June 1977, undertook to implement this methodology, keeping in mind DAI's suggested focus and AID's requirements for management useful information in deciding future resource allocations. In attempting to strike a balance between these objectives,

the Evaluation Team concentrated on measuring progress against and assessing project purpose and outputs as defined in the revised Logical Framework developed by DAI. No attempt was made, however, to assess goal level achievement or to develop measurable goal indicators, as this was believed to be premature and outside the scope of this evaluation given the time and resources available for its execution. This important task is best addressed as part of the project staff's ongoing work to develop information systems and evaluation instruments for measuring the impact of BHS and AHDS programs.

B. Revised Logical Framework

The Logical Framework is USAID's primary project design and evaluation scheme. Through a thorough examination of the Project Paper, Project Performance Track, Project Agreement, Letters of Understanding and discussions with those who participated in designing the project, the original project hypotheses, objectives, assumptions and indicator targets that signal successful achievement were specified in a revised comprehensive Logical Framework (see Annex A). This Logical Framework represents the plan of the project against which actual achievement where possible was measured by the evaluation team.

C. Information Needs

In developing the questionnaire used by the Evaluation Team, DAI identified the information that would be required to measure planned against actual achievement, to determine the causes of success or failure, to validate the assumptions and test the hypotheses. The resulting list of questions for each target and each assumption was used by the Evaluation Team as a guideline in developing needed information about each indicator and assumption.

D. Related Issues

The Logical Framework, representing only original intent did not identify related issues that the evaluation should address, such as: 1) the efficacy of fixed amount reimbursement (FAR); 2) the effect of the WFP program on maternal child health services in BHCs; 3) the provision of free drugs; 4) attention to specific needs of nomads; 5) the quantity of USAID project staff; 6) the motivation of village health workers; 7) BHC physician's private practice; and 8) the role of the provincial health officer. A separate series of questions for each issue was developed to elicit necessary information.

E. Data Collection

The questionnaire was used in interviewing individually eighteen persons, mainly U.S. project staff and management personnel. Another eleven persons in the MUPH were interviewed during two group sessions. Of necessity,

the latter sessions focused on a condensed version of the questionnaire and tended to downplay individual Afghan perceptions of project progress and problems. [See Annex B for a listing of evaluation sources.] In addition, field trips were made to existing BHCs and new construction sites in the South and in Parwan as well as to Sorobi to view the village health worker programs at first hand. Finally, a number of documents were consulted. These are identified in the Bibliography contained in Annex C.

[Each information request in the questionnaire was coded (100 and 200 series for indicators, 300 series for assumptions, and 400 series for related issues) and during the course of an interview as each subject was discussed, the reply was coded.] When the secretary typed the interview notes, the name(s) of the person(s) interviewed was put before the code number so when the notes were assembled by code number, he or she could be identified. The notes were then filed by code with a complete copy of the interview available for each team member so that his or her information base could progress in tandem. The interview notes were treated as confidential by the Evaluation Team. They were used as needed during the evaluation and were destroyed upon completion of the evaluation. Documents consulted during the evaluation were filed by subject to the degree possible so that relevant information could be retrieved quickly during the preparation of the evaluation report.

F. Data Analysis

[A preliminary analysis of data was undertaken by the evaluation team in order to brief the project officer before his departure from post in mid-July 1977. [A final analysis of each subject was done when all data collection had been completed. Subject files were assigned to each team member for preparation of summaries of information obtained. Assignments were based on the members' experience.] For example, the physician on the team examined the basic health services to be provided in BHCs, staffing requirements, and staff manuals. [Each team member developed a worksheet on each subject he or she reviewed.] [For indicators the worksheet covered current status, why, forecast and recommendations; for assumptions it decided validity and made recommendations; for relevant issues it offered conclusions and recommendations.] [These worksheets were then discussed by the team as a whole until a consensus was reached. The team also determined whether there were sufficient data to support the position adopted in the evaluation report.] [Based on these worksheets and the team's deliberations, a discussion paper reflecting its preliminary findings and tentative recommendations was prepared for briefings with USAID representatives and MOPH officials.] These discussions held August 8 and September 12 respectively proved effective in translating some evaluation concerns and recommendations into actions aimed at improving project performance. See Section VI for details.

IV. Major Conclusions

The evaluation is impressed with the progress made in the first year of the project in the following areas:

1. The AHDS program has been an encouraging innovation in the delivery of basic health services to the rural population of Afghanistan. The first model, established to serve five villages in the Sorobi area, has been well received by the local populace. Eleven village health workers, including two women, were recruited and trained to provide optimum curative and preventive services with minimum diversion of limited MOPH resources. Since the program had been functioning for only six weeks, an objective assessment of this model was not possible in time for this evaluation. A second AHDS model, an alternative to the VHW program, was established in Girishk in June. Eleven dais, traditional birth attendants, were trained to provide improved pre-natal, delivery, and post-natal care to mothers and infants. The establishment of both models, which overcame several predicated socio-cultural obstacles, is an affirmative step by the MOPH in expanding its program of the delivery of health services to the rural population.

2. The Auxiliary Nurse Midwife (ANM) training school will be running at full capacity in September this year with three classes of about 50 students each. The selection committee now is trying to pay close attention to the problem of future placement of the ANM graduates by recruiting girls from BHC sites. Thirteen teachers of the ANM school to date have returned from training in the U.S. and have been appointed to teaching jobs within the school or related positions. A teacher/pupil ratio of 1:10 has been maintained. The GOA has established an ANM position within each BHC, on a contract basis, to provide maternal child health services.

3. Comprehensive basic health service manuals for each BHC staff member have been developed, tested, and disseminated. Five mobile training teams have been established and have visited so far some 54 BHCs. They have provided on-the-job training using the BHC manual and introduced new management procedures (e.g., record keeping, inventory, etc.). Though too soon to judge its impact, the mobile training team approach promises to upgrade existing staff and the quality of services in BHCs. The preventive orientation program for doctors being transferred to BHCs is an important complement for upgrading BHC performance.

4. Construction of the first Rank I BHC at Girishk is on schedule, with 50 percent of the work complete. This attests to the high priority placed on the Rank I center. Girishk hospital has been suggested as a temporary Rank I facility until construction is completed in order to accelerate the development of the regional training and administrative center. The hospital already made space available for the first dais training program in June.

The evaluation is concerned about actual and potential problems arising in the following areas:

1. The difficulties of adequate staffing of BHCs as experienced in existing centers are also likely to harass optimal functioning of project BHCs. Since no agreement has been reached on definition of "operational" BHC, no formal consensus exists on optimal and minimal staffing of a BHC. But it seems to be mutually understood that without an ANM or other female worker in the BHC the objective of increasing the delivery of services to women and children cannot be met. Currently only 33 percent of BHCs have an ANM. Considering the importance of ANMs for achieving project purposes, placement of only 54 percent of ANM graduates into BHCs is unacceptable. At least 75 percent of ANM graduates should be assigned to BHCs. Even so, the facts show that one will not be able to place an ANM into all BHCs since many BHC sites are in areas where no girl's schools exist; thus, no candidates are available who qualify for the present requirements of ANM training. This problem, unfortunately, has been only recently recognized and alternative approaches to recruitment and training of female medical workers are only just now being explored. Incentives for work in rural areas have not been introduced to BHC staff and this might prove an obstacle not only to placing qualified personnel into remote areas, but also to retaining them in the center over a longer period of time.

2. The slow progress in construction hampers the intended expansion of health services under the project and detracts attention from the more important aspects of the project relating to health services improvement and delivery. At the time of this evaluation, only two Rank II BHCs and one Rank III BHC of eight selected in the South were actively under construction. While delays occurred in locating contractors, the major problem is that only one contractor was found for all nine BHCs in the South and he is over-extended, having insufficient workers, supervisors, and equipment to carry on construction at more than four sites at any one time. Aggravating the situation, is the contractor's inexperience in working with detailed drawings, standards and specifications coupled with insufficient MOPH staff to provide adequate supervision of the contractor's work. These same problems are present in the construction of the three incompleting Rank IIs assumed under the project.

3. The USAID Fixed Amount Reimbursement (FAR) approach has not enabled MOPH to overcome construction constraints and meet project construction targets. As a result no funds have been transferred under FAR. MOPH construction management and implementation capabilities are limited and cannot be strengthened simply with FAR incentives. FAR's incentive effect to MOPH is less financial, since money when reimbursed will go to the Ministry of Finance and is unrelated to MOPH budget allocations, than performance oriented. Since FAR serves to highlight weakness in performance, Ministry officials may press for better performance to avoid embarrassment. FAR was not designed to develop capacities where few exist. Consequently, USAID monitoring engineers have unexpectedly been required to devote considerable time and energy to providing ad hoc technical assistance to expedite construction in addition to their role of inspection and certification of

adherence to quality standards in specifications and drawings. The two roles compete for effective use of engineers' time.

4. A critical assumption was made at the outset that estimated unit costs of BHCs would not exceed those stated in the Project Paper (PP). This assumption has proved invalid. Cost estimates in the PP are on an average 52 percent below the latest USAID/CDE estimates. This substantial difference arises from: a) improved accuracy of cost estimating; b) inflation in the cost of labor, materials and transportation; and c) a 28 percent decline in the dollar/afghani exchange rate since the PP was prepared. Despite the savings effected by downgrading four Rank II to Rank III BHCs, USAID had been forced to reduce its intended contribution to construction financing from 75 percent to 59 percent on the first nine BHCs. This issue contributed to MOPH doubts about the reasonableness of USAID cost estimates and delayed the signature of Letter of Understanding No. 2 for six months.

5. None of the nine temporary facilities planned for BHC sites had been arranged as of the date of this evaluation, except informally at Girishk. Moreover, no adequate explanation has been provided by MOPH for the delay in renting temporary quarters. It is evident that the MOPH can rent buildings, since the BHC at Jamal Agha in Parwan is a rented facility. Whether delays have resulted from a lack of adequate budget provision, problems in staff recruitment, unavailability of rental facilities, or administrative inertia, MOPH assured the Evaluation Team that nine temporary centers would soon be functioning. Renting of temporary facilities can provide a headstart on resolving problems in getting a center operational, thus enabling a smooth transfer of staff and equipment into a newly constructed BHC. The purpose of establishing temporary facilities is defeated if staff and resources are provided at the expense of existing BHCs.

6. Although the AHDS program has been designed to deliver both curative and preventive services to segments of the rural population, there is, at minimum, a threat that the curative component in both models will be provided at the expense of the preventive elements. It is clear that the prevailing demand among the rural population is for curative health services. Recognizing that this is an early experimental approach to a type of health care delivery, as the experiment progresses the balance between curative and preventive service will have to be assessed. For example, so far the only incentive for the provision of preventive services is the motivation of the VHWs through training and supervision. But yet the VHWs have received little supervision.

7. Training of ANM teachers focuses very heavily on family planning though this represents only a small proportion of their subsequent teaching tasks.

8. Recognizing the trial nature of MOPH's nascent regionalization effort, it is not surprising that the details of the proposal for the

development of the position of Regional Health Officer are at present unclear. Both the MOPH and MSH staffs have indicated that the position of RHO will be created, but their conceptions of his role diverge. The potential for an ineffectual RHO or conflict between him and the existing Provincial Health Officer are factors that must be carefully considered so as not to prejudice the effective functioning of the BHS program.

9. The project design calls for substantial efforts in data collection and for the creation of an information system. Pre-project implementation surveys have largely been conducted as required. However, the extensive information system and program performance evaluations planned have not yet been implemented. Moreover, some information requirements in the PP are inappropriate to the needs of the project and unrealistic given the time-frame of the project. In view of the limited ability of the MOPH to analyze and absorb existing data, further excessive data requirements will overtax the MOPH system without contributing meaningfully to measuring project impact.

10. English language difficulties continue to haunt otherwise qualified training candidates from MOPH. Candidates have simply not been available for in-country language training for long enough periods before departure for training, as they could not be spared from work. As a result, established USAID language proficiency standards for participants have had to be consistently waived in attempts to minimize delays in the training schedule. In this process, candidates risk missing many potential benefits from training for lack of English comprehension.

11. Project control and access to 26 USAID-supplied vehicles for project purposes has been unsatisfactory. The MOPH has failed so far to account for these vehicles, as requested by USAID. An unofficial accounting indicates that some vehicles have been diverted to non-project related activities.

V. Major Recommendations

With a view to offering constructive ideas for improved output performance and forestalling possible problems in the future, the Evaluation Team makes the following recommendations:

Regarding Female Recruitment and Training

1. MOPH should continue emphasizing enrollment of ANM candidates from BHC sites.

2. MOPH should strive to assign at least 75 percent of ANM graduates to BHCs. However, 100 percent assignment is unrealistic at present owing to marriage, career, and other personal decisions.

3. If the retention rate of ANMs in BHCs proves unsatisfactory, the reasons should be identified and appropriate incentives should be developed.

4. MOPH should continue its efforts to define the position of ANM within the GOA personnel system. The possibility for incentive purposes of funneling ANMs into the civil service after a certain number of years of service should be actively explored. Similar consideration will have to be given to the position of other less trained females who will be working in the BHCs where no ANMs are available.

5. MOPH and USAID should proceed with alternative training of local women for MCH work in BHC sites until ANM candidates can be recruited, trained, and returned to the BHC.

6. On the next visit of a Santa Cruz University representative to Afghanistan, the relevance of U.S. training curriculum for ANM teachers should be reviewed with teachers and officials of the ANM school with a view to shifting its emphasis toward nurse-practitioner training.

Regarding Funding

1. AID/W should approve USAID's recent budget request for increased funding to raise the FAR financial contribution on the nine BHCs underway to the originally intended 75 percent.

2. To permit accurate calculation of funding requirements for the FY 1977 Project Agreement, MOPH and USAID engineers should meet immediately to work out cost estimate differences and agree on reasonable costs.

Regarding Construction

1. MOPH should review contractor resources (e.g., staff and equipment) and grant a contract only for as many BHCs as the contractor can reasonably handle at any one time.

2. MOPH should fill the four vacant engineering positions immediately.

3. The construction schedule should be revised and more realistic targets set, especially as regards numbers of Rank II and Rank III BHCs and completion dates.

4. If requested by MOPH, USAID should consider providing full time technical assistance to help the MOPH construction division in organizing BHC construction.

5. MOPH and USAID engineers should re-examine materials used for BHCs in light of experience to date. If originally chosen material (e.g.,

stone) proves unavailable locally and/or excessively costly or timely to deliver to a BHC site, the standards and specifications should be revised.

6. USAID/CDE has identified faulty workmanship at the Malistan BHC. USAID should refuse certification of Malistan BHC or any other site if workmanship remains substandard.

7. MOPH and USAID should consider third and in-country training for construction personnel as an alternative to U.S. training, which may be less appropriate to Afghanistan.

Regarding Rental of Temporary BHCs

✓ 1. MOPH should proceed with its plans to make nine temporary BHCs in the south operational within the next month.

✓ 2. Girishk hospital should be officially assigned as a temporary Rank I BHC and made operational.

✓ 3. MOPH should proceed with its remodelling plans for Girishk hospital from its own resources.

Regarding the Operation of BHCs

1. MOPH and USAID should agree upon a definition of "operational" BHC and formalize this in a Project Implementation Letter within the next two months. Prospective staff planning without a consensus on optimal and minimal staffing is impossible. In addition, a formal agreement has to be reached and implemented if the project BHCs are to qualify for FAR reimbursement.

2. USAID should consider assisting MOPH in BHC manpower projections, allocation and management by providing a consultant to review this question with the Ministry.

3. The MOPH should intensify mobile team trainers' training and expand the number of training teams.

Regarding the AHDS Program

1. The provision of preventive services in the AHDS program needs careful evaluation. The program evaluation should be designed to provide as much information on the progress of the preventive component as possible in order to avoid an over-emphasis on curative care. The need for incentives to provide preventive services should be anticipated and they should be incorporated into the program.

Regarding the Information System

1. MOPH, through its Health Information Bureau and MSH should determine the minimal, essential data components needed for effective management of the BIS program and begin strengthening MOPH's data analysis capability. This should help ensure that the data collected is used to its fullest potential.

Regarding Fixed Amount Reimbursement (FAR)

1. USAID should continue to use FAR as a worthwhile device for highlighting specific MOPH managerial and implementation deficiencies and as a convenient financing method which provides ultimate insurance to USAID against paying for BHCs which are faulty in construction or inoperative. FAR alone should not be expected, however, to develop capacities where none exist. Supplemented by technical assistance in construction, FAR can serve as an effective assistance tool for constructing health centers.

Regarding the Roles of the Provincial Health Officer and the Regional Health Officer

1. As the regionalization experiment evolves, the functions of the Regional Health Officer must be carefully designed to complement, rather than compete with the role of the Provincial Health Officer.

Regarding English Language Training

1. A more specialized intensive language program at MOPH with experienced native-speaking teachers should be explored for participant training candidates (actual and potential) in order to accommodate training and work requirements rationally during office hours.

2. Third and in-country training opportunities should be explored and taken whenever possible, since the training may be more appropriate and the English requirements less demanding.

3. The participant training schedule should be reviewed, and revised if appropriate, to account for language difficulties.

Regarding Project Vehicles

1. MOPH should provide USAID with an official account of the 26 vehicles supplied for project activities.

2. If vehicles have been diverted, they should be reassigned to project activities.

VI. Actions Resulting from this Evaluation

1. Recognizing the slow progress in BHC construction and the lack of agreement on estimated costs and funding, MOPH and USAID have informally agreed on the following:

- a) MOPH will assign the necessary construction personnel and devise a construction inspection and supervision plan to be submitted to USAID for review;
- b) USAID will sympathetically consider a request for technical assistance to help the MOPH Construction Directorate.
- c) MOPH will explore various means of resolving the problems with unregistered contractors.
- d) MOPH and USAID have worked out reasonable cost estimates for the first 12 BHCs.
- e) USAID will meet its agreement to reimburse 75 percent of completed BHCs. Funds have already been obligated to cover the nine BHCs already under construction.
- f) USAID will not obligate funds for additional BHCs, however, until construction performance so warrants.

2. Five buildings have now been leased and partial staffs appointed to establish temporary RHCs. USAID has received a letter designating the Girishk hospital as part of the Rank I training center.

3. The UC/SC representative who visited Afghanistan in September discussed the content of the UC/SC curriculum for ANM school faculty and revisions are under development.

4. The MOPH has officially requested USAID to provide an advisor for one year plus some short-term consultants to assist the Ministry to develop "a plan of action for manpower planning, facility design, personnel management, curriculum design and medical research".

5. The MOPH indicate a letter on the assignment of USAID-supplied vehicles has been forwarded to USAID through the Ministry of Planning. USAID has not yet received the letter.

VII. Conclusions

Based on the first year's experience the project shows promising prospects of having a favorable impact on Afghanistan's Basic Health Service Delivery System.

While some of the findings in this report are critical of the performance in certain aspects of the project to date, the Evaluation Team is delighted that they have not been eclipsed by attempts to explain and excuse them, but rather have been used in a spirit of openness, collaboration and common purpose to stimulate serious discussion among project staff to resolve quickly some of the implementation problems facing the project. It is hoped that this process may continue and help forestall foreseeable problems from impairing future progress.

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BHS Evaluation Methodology - Part II
REVISED LOGICAL FRAMEWORK FOR EVALUATION

ANNEX A

PURPOSE

Access to basic health services, with emphasis on services for women and children, provided to 830,000 persons living in fifty Minor Civil Divisions within four of Afghanistan's six Health Regions.

Elements of one or more Alternative Health Delivery Systems (AHDS), demonstrated effective in providing a minimal health service for those persons who will not have reasonable access to a BHC, assessed to be replicable and feasible financially and administratively.

END OF PROJECT STATUS

BHS

A. Each operational BHC provides:

1. diagnosis
2. effective treatment for 80% of diseases presented
3. referrals to provincial hospitals
4. FP education and service
5. midwifery and MCH service
6. health education for nutrition and sanitation
7. vaccination services by ANM and vaccinator.

B. Average BHC attendance 50 patients per day.

C. The proportion of women and children seeking health services increasingly corresponds with their numbers in the target population.

D. x% of population having reasonable access to BHC utilize BHC services at least one time per year.

AHDS

A. Effective model provides service to 3,000 persons.

B. Workers provide simple diagnosis and treatment (or referral) for:

1. Gastro-enteritis and children's diarrhea
2. Conjunctivitis and trachoma
3. "aches and pains"
4. Skin infections
5. worms
6. Bronchitis and pneumonia

C. Workers gain confidence of their clients and provide advice on:

1. nutrition of mothers and children
2. personal hygiene
3. community sanitation
4. weaning practices
5. first aid
6. food storage and preparation
7. family planning and contraceptive service
8. care of children

OUTPUT 1

50 BHCs constructed and operational

OUTPUT INDICATORS

- A. Facilities rented, staffed and equipped for up to 20 BHCs (4 of which are Rank I).
- B. Rented facilities are all in areas in which new BHC construction is to be completed within 18 months of start of rental.
- C. Site selection for new BHCs has following criteria (interalia):
 - (1) population size and distribution to insure both intensive benefits and cost/effective coverage on a per-capita basis.
 - (2) expected acceptance by population
 - (3) perceived health needs
 - (4) administrative requirements
 - (5) no existing health services
- D. 4 Rank I centers completed.
 - (1) one in each of four Health Regions
 - (2) each center serves as administrative and training center for Health Region.
- E. 39 Rank II (10 room polyclinic) centers completed.
- F. 4 Rank III (6 room polyclinic) centers completed.
- G. Completed BHCs meet operational criteria as established in LOU #3.
- H. 3 Rank II centers, partially completed prior to project implementation, completed.
- I. All centers have adjacent living quarters.
- J. Each Rank I center has training facility of two classrooms (for 20 students each), one for lecture and seminar programs, one for audio-visual instruction.

OUTPUT 2

BHC personnel trained and assigned.

OUTPUT INDICATORS

A. U.S. training:

- (1) Masters Degrees in Health Planning completed by two persons of Pres. of Coordination and Planning.
- (2) Training in construction, construction supervision, buildings and equipment maintenance completed by 10 persons of Division of Eng.
- (3) Training in supply and transport management completed by two persons of Pres. of Administration
- (4) Training in project related management skills completed by twelve persons of Pres. of Administration
- (5) Masters Degrees in rural health administration completed by two persons of General Directorate of Basic Health Services.

B. Third-Country Training:

Twelve one-month training programs completed.

C. In-Country Training:

Training of trainers started by January 1, 1977. The design and implementation of in-service training programs in Afghanistan for all BHS personnel.

- D. MOFH employees trained in U.S. return to same or higher positions in the MOFH Presidencies for which the training is being provided. Assignments are for not less than two years.**

OUTPUT 3

BHC supply system modified and expanded.

OUTPUT INDICATORS

- A. Drug (medicines) formulary for BHC adequate for illnesses treated.**
- B. Types and quantities of drugs supplied to BHCs becomes increasingly dependent on requests from and assessed needs of individual BHCs.**
- C. Increased decentralization of supply decision making involving BHC personnel and Provincial and Regional supervisors.**
- D. Warehousing provided at Rank I centers, Provincial centers and at BHCs.**
- E. Continuous supply of basic drugs, contraceptives, supplies and training materials at all Phase I BHCs.**
- F. Agreement on sub-system designs, job descriptions for logistics personnel, work manuals by March, 1977.**
- G. Family medicament and contraceptive kits developed, demonstrations conducted through a few BHCs, resupply system developed.**
- H. Contraceptive stock sufficient to take care of 15 percent of female population within access of BHCs and provide for some of the females who live in neither the AFGA nor Phase I project areas.**

OUTPUT 4

BHC information system operating.

OUTPUT INDICATORS

- A. MOPH systematically examines and reports on effectiveness of BHCs.
Reports include:
 - (1) evaluation of citizen awareness and utilization of health services
 - (2) effectiveness of BHC personnel in such "outreach" services as health education and family planning motivation
 - (3) effectiveness of services for women and children
 - (4) staff training and motivation,
 - (5) changes in morbidity, mortality and infant/childhood malnutrition among the citizens having access to the BHC services.
- B. Individual client health histories developed.
- C. Data to construct health "profile" of people served in a particular geographical area developed.
- D. Client record and summary report system developed and agreed upon early in Phase I.
- E. Record and report system included in medical and para-medical health worker manuals and in-service training programs.
- F. BHC inspections include monitoring and retraining BHC personnel in information system operation.
- G. Client data collection and reporting methods tested for AHDS models.
- H. Information system provides basis for estimating:
 - (1) Proportion of population being served
 - (2) Perceptions of importance of various diseases
 - (3) Shifting patterns of disease
 - (4) Supply system functions
 - (5) Short and long run financial planning for MOPH
- I. MOPH will provide to USAID a quarterly report (no later than 30 days after the end of each reporting period) on the percentage of construction completed for each BHC.

OUTPUT 5

ANM School operating at optimal level.

OUTPUT INDICATORS

- A. Administrative and teaching personnel of the ANM school provided in numbers insuring a teacher-pupil ratio of one to ten when the school is operating at full strength.**
- B. Twelve ANM faculty and full time professional/administrative personnel each receive nine months of academic training in the U.S.**
- C. 310 students admitted to 18-month ANM course of which 140 graduated by end of Phase I.**
- D. Participants trained for the ANM school return to full time faculty or administrative positions in the ANM school on completion of their training in the US.**

Two or more AHDS designed and tested.

OUTPUT INDICATORS

AHDS models designed and tested to provide answers to following questions:

1. Can AHDS workers be recruited, trained and motivated to deliver services which are effective and accepted by the people?
2. Can viable purchase, pricing and cash/materials systems be developed and sustained at AHDS levels?
3. Are training and supervising designs adequate?
4. Are the services selected for AHDS trials the most important and acceptable to the people?
5. Are other delivery agents more likely to be accepted than those chosen for Phase I AHDS models?
6. Do the results of the pilots justify either further trials or a phased expansion for the whole nation?

ASSUMPTIONS

PURPOSE TO GOAL:

1. The MOPH will provide continued manpower and budgetary support to its rural, preventive health care program.
2. Donor assistance to MOPH programs will, as a minimum, be maintained at currently planned levels.
3. GOA places a high priority on the provision of expanded public health services.
4. Epidemics are contained.
5. No major food shortages occur.

OUTPUT TO PURPOSE:

1. The MOPH will provide from its ordinary budget in this and subsequent years sufficient funds for the recurring costs of operating at an agreed minimal level the BHCs financed in the Phase I project.
2. The MOPH will assign graduates of the AMM school, upon satisfactory completion of the full course, to BHCs for a period of not less than two years and ___% of these graduates will remain at assigned BHC for at least two years.
3. Villagers will be more likely to accept services and education from persons known to them.

INPUT TO OUTPUT:

1. BHS institutional and personal motivations are sufficient to sustain required effort.
2. Villagers receptive and willing to participate in AHDS model(s).
3. MOPH implements rational medicine/drug policy and insures inventory levels at BHCs.
4. The MOPH will be able to make whatever administrative changes may be necessary to meet project objectives.
5. The MOPH will designate 7 officials qualified by education and experience to serve as counterparts to the USAID provided expatriate advisory personnel.
6. The MOPH will nominate qualified MOPH employees for project training abroad.
7. Qualified candidates for all targeted BHC positions are available.
8. Currently inadequate English language capabilities of participant training candidates can be sufficiently improved by special language programs to meet participant training schedule.

INPUT TO OUTPUT ASSUMPTIONS (continued):

9. Estimated unit costs of BHCs will not exceed those stated in Project Paper.
10. Construction of BHCs begins not later than 60 days after site selection.
11. Practical survey instruments can be developed and implemented by Afghan interviewing teams and can be planned, conducted and analyzed within less than six months at reasonable cost.
12. UNICEF contributions to project operations will be maintained as planned.
13. Other AHDS experiments will be undertaken outside of project that allows comparison of AHDS model results against other alternatives.
14. The MOPH will establish, within each BHC, an authorized position for a trained ANM (graduate of the ANM school) with remuneration commensurate with experience and training and customary for this category under the rules and regulations of the GOA.
15. The MOPH will insure adequate storage and control of and access to all USAID commodities provided to project.
16. The MOPH demands for services of project staff outside of project specific activities will not unduly restrict output achievement.

ISSUES

1. Efficacy of FAR system.
2. Effect of WFP program in BHC MCH services.
3. Provision of free drugs and contraceptives to BHC and AIDS clientele.
4. Attention to specific needs of nomads.
5. Quantity of USAID project staff.
6. Hospitals drawing off AMMs. (*incorporated with DP Assumption 2*)
7. Motivation of VHW to provide preventative care in contrast with curative care.
8. Need for increased AID funding of Phase I. (*incorporated 10 Assumption 9*)
9. BHC physicians' private practice conflict with government responsibility.
10. *PHO vs PRO*

HIGHER ORDER OBJECTIVES AND LONG-TERM BENEFITS

Decreased birth rate

Longer life expectancy

A more vigorous, alert, innovative society

Improved productivity

Fewer People disabled and/or deformed by disease or crude traditional medical practices

Fewer days of work lost because of illness and morbidity

Increased yield on human capital

Rise in dependency ratio with relatively small economically productive population

Increased participation of women in socio-economic activities

These higher order objectives and long-term benefits of the project are identified in the Project Paper. They have a place on the Logical Framework. In the Assumptions column only three boxes are used for recording the assumptions (the three lower boxes). The upper box can be used to record these other objectives. The idea is that the goal is important in order to achieve other objectives that may also be important to the host government and/or AID. This use of the Logical Framework communicates the expected impact that the goal is to have. However, how much impact or the priority of these objectives are not communicated.

Project Goal: To improve the health of Afghan population not now having access to effective health education and services due largely to circumstances of residence, poverty, sex and age. These are mostly the rural people who comprise 85% of the population.

Goal Indicators: In brief, they are confined to morbidity and mortality rates related to malnutrition, measles, pneumonia, diarrhea/dysentery w/dehydration. Also to be measured in change in percent of contraceptive acceptors and number of additional children desired at parity of two.

Evaluation Sources

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Mr. R. Patterson, Assistant Program Officer, USAID
Dr. R. Hooker, Program Economist, USAID
Mr. L. Gibson, Gen. Engineering Advisor, USAID
Mr. G. Thomas, CDE Engineering Advisor, USAID

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A N N E X D

EVALUATION WORKSHEETS

EOP INDICATOR

LOGICAL FRAMEWORK TARGET

JUNE 1, 1977

101 A - Each operational BHC provides:

- 1) diagnosis
- 2) effective treatment for 80% of diseases presented
- 3) referrals to provincial hospitals
- 4) FP education & service
- 5) midwifery and MCH service
- 6) health education for nutrition & sanitation
- 7) vaccination services by ANM and vaccinator.

Three BHC's operational July 1977

Current Status

- 1) Target not met; no project BHC operational.
- 2) No agreement has been reached between USAID and MOPH upon definition of "operational" BHC.
- 3) Important information about BHC's was gathered from existing facilities.
- 4) At present only some of the BHC's provide the full range of above listed services.
- 5) BHC's included in Parwan study show considerably improved services and can serve as model for "operational" BHC.

Why

- 1) Construction not completed. See under 205.
- 2) Definition of "operational" BHC remains to be agreed upon.
- 3) Many of the problems occurring at this stage of the development of BHC's are of general nature and are very likely to harass successful operation of new center similarly.
- 4) The biggest problem at this point is adequate staffing of BHC's with well trained personnel; female staff being the most critical part.

5) The Parwan study proved the importance of in-service training and regular supervision to improved services. Merely physical expansion of BHS without upgrading of existing services would not really serve the needs of the people of Aghanistan.

Forecast

- 1) Delay in construction makes a revised time-schedule necessary.
- 2) Definition of an "operational" BHC will be negotiated and agreed upon.
- 3) Services in existing BHC's can be expected to gradually improve through in-service training and reorganization in accordance with experiences gathered in the Parwan study.
- 4) Difficulties in optimal staffing of BHC's are likely to continue, major bottlenecks being ANM's (or other female workers) and Laboratory Technicians.
- 5) Expansion and improvement of services are expected to proceed parallel.

Recommendations

- 1) Develop revised time schedule for completion of construction.
- 2) MOPH and USAID should agree upon definition of "operational" BHC and formalize this in a P.L.L. within the next two months. Prospective staff planning without a consensus on optimal and minimal staffing is impossible. In addition a formal agreement has to be reached and implemented in the project BHC's to qualify for FAR reimbursement.

| <u>EOP INDICATOR</u> | |
|--|--|
| LOGICAL FRAMEWORK TARGET | JUNE 1, 1977 TARGET |
| 102 BHS B - Average BHC attendance 50 patients per day | No interim target (for project BHC's) |

Current Status

No project BHC's operational at present. From existing BHC's enough information was gathered to conclude that 50 patients per day seems a reasonable target.

Recommendations

Evaluation for new BHC's one year after being operational recommended.

EOP INDICATOR

LOGICAL FRAMEWORK TARGET

103 C - The proportion of women & children seeking health services increasingly corresponds with their numbers in the target population.

JUNE 1, 1977 TARGET

No interim target
(for project BHC's)

Current Status

Since no project BHC's are operational, information was collected from existing BHC's. The attendance of women in BHC's depends highly on the presence of an ANM (or other female worker). Where an ANM is present the number of women and children seeking services is increasing.

Why

The placement of an ANM or other female worker in BHC's is essential for successful delivery of services to women and children given cultural background.

Forecast

With the placement of ANM's or other female workers in BHC's the proportion of women and children in the BHC clientele is likely to rise to the actual proportion in the population.

Recommendations

MOPH should continue to strive at placing an ANM into each BHC and pursue alternative training of local women for MCH work in BHC sites until ANM candidates can be recruited, trained and returned to BHC.

| <u>EOP INDICATOR</u> | |
|---|----------------------------|
| <u>LOGICAL FRAMEWORK TARGET</u> | <u>JUNE 1, 1977 TARGET</u> |
| 104 AHDS A - Effective model provides service to 3,000 persons. | |

Current Status

One AHDS model, which serves several villages in the Sorobi area, is currently functional. Although the program has had an encouraging start, progress achieved toward reaching this target has not been quantified or qualified. Similarly, a second AHDS model, the dai program in Girishk, has been designed and training was recently completed.

Why

Evaluation of program effectiveness is premature. The AHDS model in Sorobi with 11 VHW's has been in operation for only six weeks. The 11 dais in Girishk completed their training in June.

Forecast

This target as stated is ambiguously worded and less clarified cannot serve as a basis for rational assessment. It is not clear whether services are to be delivered to an unspecified number of people in an area having a population of 3,000, or to 3,000 clients from a far greater population. It is also unclear whether the figure refers to 3,000 separate individuals or 3,000 treatments to a smaller number of clients, many of whom may be repeaters. The period of time in which these services will be provided (i.e., each year, during Phase I, or life of project) should also be specified. Effectiveness of the program will depend on the balance struck between the incentives to VHWs to provide curative care and the incentives for the provision of preventative services.

Recommendations

1. The target should be specified more clearly.
2. Incentives should be studied with a view to strengthening the preventative side of the program.

| LOGICAL FRAMEWORK TARGET | <u>EOP INDICATOR</u> | JUNE 1, 1977 TARGET |
|---|----------------------|---------------------|
| 105 AHDS B. Workers provide simple diagnosis & treatment (or referral) for: 1. Gastro-enteritis & children's diarrhea 2. Conjunctivitis and trachoma 3. "Aches and Pains" 4. Skin infections 5. Worms 6. Bronchitis and pneumonia | | |

Current Status

Presently only the AHDS VHW program in Sorobi is functioning. Eleven village health workers have been trained to provide the diagnoses and treatment called for in the target. Assessment of their success has not yet been made.

Why

The program has been functioning for only six weeks. Evaluation of the success of the program will not be made until late 1977.

Recommendations

1. The evaluation of the Sorobi model should take place as planned.

| <u>EOP INDICATOR</u> | JUNE 1, 1977 TARGET |
|---|---------------------|
| <p data-bbox="267 420 654 452">LOGICAL FRAMEWORK TARGET</p> <p data-bbox="267 485 828 586">106 AHDS C - Workers gain confidence of their clients & provide advice on:</p> <ol data-bbox="332 620 868 916" style="list-style-type: none">1. nutrition of mothers & children2. personal hygiene3. community sanitation4. weaning practices5. first aid6. food storage & preparation7. family planning & contraceptive service8. care of children | |

Current Status

Progress toward meeting this target has not been assessed.

Why

The VHW program has been functioning for only six weeks. Evaluation of progress toward meeting this target is not planned until late 1977.

Forecast

It has been recognized that the demand for curative care is greater than that for preventative services. Monetary incentives are being provided to VHW's for the delivery of curative services. For this reason it is possible that preventative services will be neglected by VHW's.

Recommendations

1. The program evaluation should be designed to provide as much information as possible on the progress of the preventative component.
2. Incentives as recommended in Issue No. 407 should be considered as a means of encouraging VHW's to provide preventative services.

| <u>OUTPUT INDICATOR</u> | |
|--|----------------------------|
| LOGICAL FRAMEWORK TARGET | MAY 1977 (per LOU #1) |
| 201A - Facilities rented, staffed and equipped for up to 20 BHC's (4 of which are Rank I). | 9 rented BHC's operational |

Current Status

No temporary facilities have been arranged to date, except informally at Girishk where the provincial hospital has made some space available for training. Even these facilities are not used yet as an operational BHC.

Why

1. No adequate explanation was obtained for the delay in renting temporary quarters. It is evident that MOPH can rent buildings, since the BHC at Jamal Agha, Parwan is a rented facility. A lack of adequate budget provision for rent as well as remodeling cost, problems in staff recruitment, unavailability of rental facilities, or administrative inertia are all possible explanations.

2. Delay at Ghirisk relates to a misunderstanding on MOPH's part that USAID would cover remodeling costs. MOPH is now proceeding to make its own funds available for this purpose.

Forecast

MOPH officials indicate that seven leases have been signed and contacts with one community initiated for the rental of temporary BHC facilities and that personnel for staffing all nine temporary facilities have been designated. The same officials predict that within a month all nine temporary BHC's, including Girishk will be operational. With Ramazan starting August 15, this may be overly optimistic.

Recommendations

1. MOPH should proceed with plans to make nine temporary BHC's in the South operational within next month.

2. Girishk hospital should be officially assigned as a temporary BHC Rank I and made operational.

3. MOPH should proceed with remodelling plans for Girishk hospital from its own resources.
4. It should be recognized that temporary facilities are unlikely to be immediately fully staffed, especially as they relate to ANM's from areas given 18-month training cycle, but a partially staffed, temporary BHC is preferable to no BHC.
5. In efforts to set up operational BHC's on a temporary basis staffing requirements should not be met at the expense of existing BHC's.
6. Where staff shortages arise in temporary facilities, alternative recruiting and training programs should be explored, especially for female workers.
7. Staffing and equipping problems should be resolved in time to inaugurate newly constructed BHC's with a full staff complement and adequate equipment.

OUTPUT INDICATOR

LOGICAL FRAMEWORK TARGET

204 - Four Rank I centers completed
(1) one in each of 4 Health
Regions;
(2) each center serves as
administrative training center
for Health Regions

JUNE 1, 1977 TARGET

One Rank I BHC 50% complete
(LOU #1)

Current Status

As of June 1 using CDE's weighted percent calculations, construction of the Girishk Rank I BHC was 47% complete. During June additional work has brought construction to 50%. The Girishk hospital has made space available for regional training programs. Sites were selected for two more Rank I's at Balkh and Baghlan in April, and construction has started at Baghlan.

Why

1. Girishk was the first construction site to get underway in December 1976.
2. Girishk is on the main road, which eases transportation problems
3. The contractor has placed greater priority on completing Girishk than other BHC's.
4. Girishk hospital was available as a temporary training facility.

Forecast

1. Girishk Rank I BHC can be completed by July 1978 as planned. Adequate budget provision for staff and supplies for Girishk has been made. If Girishk hospital is designated and staffed as a temporary BHC, Girishk can be expected to become operational by July 1978.
2. Balkh and Baghlan are expected to be completed 18 months from start of construction.

Recommendations

1. Girishk hospital should be officially assigned as a temporary Rank I BHC.
2. Construction should be initiated at Balkh and Baghlan as soon as possible.

OUTPUT INDICATOR

| <u>LOGICAL FRAMEWORK TARGET</u> | <u>JUNE 1, 1977 TARGET</u> |
|--|---|
| 205 - 39 new Rank II (10-room polyclinic) centers completed. | 3 new Rank II centers 50% complete (LOU #1) |

Current Status

1. Of three Rank II sites selected in the South, Arghandab in Kandahar is farthest along. By June 1 only 34% of the construction was complete but as of July 31, 53% had been completed. Arghandab is characterized by relatively good quality work. At Sarban Qala in Helmand only the foundation has been excavated and at Kajakai in Helmand construction has yet to start.
2. Two Rank II sites were selected in April in Zabul and Takhar.

Why

1. Delays arose in finding contractors in the South, also with winter coming, new sites had to be selected in Kandahar and Helmand rather than proceeding with Ghazni sites where winter construction is not feasible.
2. Only one contractor was found for all nine BHC's. It is obvious that the contractor is overextended. He has insufficient workers, supervisors, and equipment. He has been able to carry on construction at a maximum of four sites at any one time.
3. The contractor is not subject to any penalty if he fails to meet deadlines. Moreover, it seems that the 50% target was not a part of the contract, which only requires that the BHC's be completed within 18 months.
4. The contractor is not used to working with detailed drawings and specifications and often cuts corners. So, upon inspection, work must be done over.
5. MOPH construction staff is insufficient to provide adequate supervision of contractor work.
6. Construction materials are not always locally available. Delays have resulted from having to transport materials long distances.

Forecast

It is estimated that each BHC will take 18 months of construction to complete. Accordingly, Arghandab can be completed by September 1978 on schedule, but Sarban Qala and especially Kajakai are unlikely to be completed before spring 1979 at the current rate of progress. Moreover, 39 Rank II BHC's are no longer a relevant target since many Rank II's are likely to be downgraded to Rank III's. The target of completing 43 new Rank II and Rank III BHC's by September 1979 will require considerably improved construction performance on the part of contractors and effective management and supervision on the part of the MOPH construction division. September 1980 may be a more realistic time frame, given MOPH estimate that it can manage construction of 20 BHC's at any one time. Thus, 40 remaining BHC's will require 36 months to complete.

Recommendations

1. MOPH should review contractor resources (e.g., staff and equipment) and grant a contract only for as many BHC's as the contractor can reasonably handle at any one time.
2. MOPH should consider including a penalty clause for non-performance by target date in all construction contracts.
3. MOPH should fill four vacant engineering positions immediately.
4. The construction schedule should be revised and more realistic targets set, especially as regards numbers of Rank II versus Rank III BHC's.
5. USAID should consider providing technical assistance to the MOPH construction division to help in organizing, scheduling and supervising construction.
6. MOPH and USAID engineers should re-examine materials used for construction in light of experience to date. If originally chosen material (e.g., stone) proves unavailable locally or excessively costly or timely to deliver to BHC site, the standards and specifications should be revised.

OUTPUT INDICATOR

LOGICAL FRAMEWORK TARGET

206 - 4 Rank III (6-room polyclinic) centers completed.

JUNE 1, 1977 TARGET

5 new Rank III Centers 50% complete (LOU #1)

Current Status

1. Of the five Rank III sites selected in the South, Shega in Kandahar is the only BHC currently under construction. As of June 1 it was 50% complete, but adherence to work specifications is lax. Work on Washir BHC in Helmand has been stopped since April, while work on Shawaliote, Naish, and Ghorak, all in Kandahar, has yet to start.

2. Nine additional Rank III sites in the North were selected in April 1977.

Why

Reasons for slow construction progress are the same as cited under 205

Forecast

See 205

Recommendations

See 205

| <u>OUTPUT INDICATOR</u> | |
|--|--------------------------------------|
| <u>LOGICAL FRAMEWORK TARGET</u> | <u>JUNE 1, 1977 TARGET</u> |
| 208 - 3 Rank II centers, partially completed prior to project implementation, completed. | 3 Rank II centers completed (LOU #1) |

Current Status

1. Baraki Rajan BHC in Logar as of 5/18 was 62% complete and workmanship is acceptable to CDE.
2. Nawa BHC in Ghazni as of 5/18 was 75% complete and workmanship is acceptable to CDE.
3. Malistan BHC in Ghazni as of 5/18 was 48% complete, but stone wall and concrete roof slab were substandard so workmanship is not acceptable to CDE.

Why

1. Slow progress is due to contractor being overextended and other problems discussed under 205.
2. Quality of these BHC's is less than what will be acceptable for new BHC's, since no approved drawings and specifications are followed by contractor.
3. Problems at Malistan BHC stem from inadequate control and supervision of work at site.

Forecast

Malistan is unlikely to be eligible for reimbursement under FAR.

Recommendations

1. MOPH should ensure that faulty workmanship at Malistan is corrected before it is plastered over.
2. USAID should refuse certification if workmanship on Malistan or any other site remains substandard.

OUTPUT INDICATOR

LOGICAL FRAMEWORK TARGET

JUNE 1, 1977 TARGET

- 211 - U.S. training:
- 1) Masters Degrees in Health Planning completed by two persons of Pres. of Coordination & Planning.
 - 2) Training in construction, construction supervision, buildings & equipment maintenance completed by 10 persons of Division of Eng.
 - 3) Training in supply & transport management completed by two persons of Pres. of Administration.
 - 4) Training in project related management skills completed by twelve persons of Pres. of Administration
 - 5) Masters Degrees in rural health administration completed by two persons of General Directorate of Basic Health Services.

Current Status

- (1) One person in training in USA
- (2) Four persons in language training
- (3) One person designated
- (4) Two persons completed U.S. training
- (5) Two persons in training in USA

Why

The main delay in the U.S. training lies in the language problems of candidates. The ministries have difficulties in releasing larger numbers of their staff at the same time for half of the day to attend language classes.

OUTPUT INDICATOR

LOGICAL FRAMEWORK TARGET

JUNE 1, 1977 TARGET

212 ⁰ - Third-Country Training:
Twelve one-month training
programs completed.

No interim target.

Current Status

Third country training was not started during first year of program.

Why

Appropriate training programs were not identified.

Forecast

The question of third country training is likely to gain more importance as an alternative to U.S. training.

Recommendations

Discuss third country training and identify suitable programs.

| | <u>OUTPUT INDICATOR</u> |
|--|-------------------------|
| LOGICAL FRAMEWORK TARGET | JUNE 1, 1977 TARGET |
| 213 - In-Country Training: Training of trainers started by January 1, 1977. The design & implementation of in- service training pro - grams in Afghanistan for all BHS personnel. | |

Current Status

- 1) Training of trainers started as planned.
- 2) To date five permanent mobile training teams operative.
- 3) Skills and knowledge of most trainers not yet adequate.

Why

Former training of trainers often insufficient, little orientation on public health in their education.

Forecast

Capability of trainers will be improved through repeated training. Number of training teams will be increased. Monotony of work and lack of incentives might lead to deterioration of performance.

Recommendations

Continue and intensify trainers' training. Increase number of training teams. Give incentives to make their work more attractive.

OUTPUT INDICATOR

LOGICAL FRAMEWORK TARGET

JUNE 1, 1977

214 - MOPH employees trained in the U.S. return to same or higher positions in the MOPH Presidencies for which the training is being provided. Assignments are for not less than two years.

Current Status

Up to now this has been the policy of MOPH. There are no cases known where this has not been the practice.

Why

Qualified people are needed in project-related positions.

Forecast

Competing demand for qualified people within MOPH will remain. The challenge for MOPH will be to resist pressure to put these trained people in non-project related positions.

OUTPUT INDICATOR

LOGICAL FRAMEWORK TARGET

JUNE 1, 1977 TARGET

215 3A - Drugs (medicines)
formulary for BHC
adequate for illnesses
treated.

Current Status

Drugs on list are adequate, however, up to now always shortage of drugs in BHC's.

OUTPUT INDICATOR

LOGICAL FRAMEWORK TARGET

JUNE 1, 1977

216. - Types & quantities of drugs supplied to BHC's become increasingly dependent on requests from & assessed needs of individual BHC's.

Current Status

Drug management and supply system is in process of reorganization. Impact of changes on BHC level cannot be assessed at present. See also Issue No. 403 which discusses drug policy in general.

Recommendations

Evaluation after approximately 12-18 months recommended.

| <u>OUTPUT INDICATOR</u> | |
|---|----------------------------|
| <u>LOGICAL FRAMEWORK TARGET</u> | <u>JUNE 1, 1977 TARGET</u> |
| 217 - Increased decentralization of supply decision making involving BHC personnel and Provincial and Regional supervisors. | |

Current Status

There is no evidence that decision making regarding supplies has been decentralized. Indeed, every indication is to the contrary. All BHC's receive standard amounts of drugs listed in the BHC formulary. There is no provision for interim replenishment of expended supplies which are allotted for one year. This target has not been met yet.

Why

The system for decentralizing drug logistics has not yet been implemented.

Forecast

Until logistic systems for the support of decentralized decision making regarding drugs are developed, the supply of certain drugs in many BHC's will be inadequate to meet demand. Drugs available in local pharmacies will have to be prescribed. In cases where pharmacies do not exist or clients cannot afford to purchase drugs, treatment will not be effected. This inadequacy undermines the MOPH policy of providing free drugs.

| <u>OUTPUT INDICATOR</u> | |
|---|----------------------------|
| <u>LOGICAL FRAMEWORK TARGET</u> | <u>JUNE 1, 1977 TARGET</u> |
| 218 - Warehousing provided at Rank I centers, Provincial Centers and at BHC's | |

Current Status

This target has not been met. Cabinet space for the storage of drugs at existing BHC's is inadequate.

Why

There are at present no Rank I Centers or targeted BHC's in operation.

Forecast

Designs for targeted BHC's have provided for adequate storage space.

Recommendations

| <u>OUTPUT INDICATOR</u> | |
|---|---------------------|
| LOGICAL FRAMEWORK TARGET | JUNE 1, 1977 TARGET |
| 219 - Continuous supply of basic drugs, contraceptives, supplies & training materials at all Phase I BHC's. | No interim target |

Current Status

- 1) No Phase I BHC operational
- 2) Drug supply in existing BHC's at present inadequate.
- 3) Drug supply and administration system is in a process of reorganization.

For further aspect on drug policy see Issue No. 403.

Recommendations

This question should be re-examined when project BHC's are operational and changes in MOPH drug administration effective.

OUTPUT INDICATOR

LOGICAL FRAMEWORK TARGET

JUNE 1, 1977 TARGET

220 - Agreement on sub-system designs, job descriptions for logistics personnel, work manuals by March 1977.

Current Status

This target has not been met. General agreement has been reached on the design of the system. Job descriptions have been prepared for the BHC component. Job descriptions for the Central Logistics Office have not yet been finalized.

Why

There is as yet no agreement between the MOPH and MSH on who will prepare the job descriptions and in what detail.

Forecast

Unless the job descriptions are prepared, the logistics system cannot be finalized. This will make decentralized drug supply impossible.

Recommendations

1. The job descriptions should be prepared and the logistics system developed.

| <u>OUTPUT INDICATOR</u> | |
|--|----------------------|
| LOGICAL FRAMEWORK TARGET | JUNE 1, 1977, TARGET |
| 221 - Family medication & contraceptive kits developed, demonstrations conducted through a few BHC's, resupply system developed. | No interim target |

Current Status

The idea of "family" kit was dropped. Now kits for MCH are provided by UNICEF and distributed to BHC's. The VHW's are provided with basic drugs which they give out to their clientele for a small fee which serves to pay for new drugs and leaves small surplus as their profit.

Why

N/A

Forecast

N/A

Recommendations

N/A

| <u>OUTPUT INDICATOR</u> | |
|--|-------------------|
| LOGICAL FRAMEWORK TARGET | J1 |
| 222 - Contraceptive stock sufficient to take care of 15% of female population within access of BHC's & provide for some of the females who live in neither the AFGA nor Phase I project areas. | No interim target |

Current Status

Contraceptive stock is adequate for expected requirements of BHC's.

Why

The target of 15% of female population seems reasonable but time required to achieve this goal is unknown.

Forecast

No major problems in providing sufficient amounts of contraceptives are anticipated. So far Family Planning is not propagated very strongly. The demand probably will grow slowly.

Recommendations

Family Planning should be stressed as health means and should be integrated into the MCH services.

| <u>OUTPUT INDICATOR</u> | |
|--|----------------------------|
| LOGICAL FRAMEWORK TARGET | JUNE 1, 1977 TARGET |
| 223 - MOPH systematically examines & reports on effectiveness of BHC's. Reports include: 1) evaluation of citizen awareness & utilization of health services; 2) effectiveness of BHC personnel in such "outreach" services as health education & family planning motivation; 3) effectiveness of services for women & children; 4) staff training & motivation; 5) changes in morbidity, mortality and infant/childhood malnutrition among the citizens having access to the BHC services. | |

Current Status

This target has not been met. Assessment of BHC staff training has been initiated as part of the mobile training team program. See target 213.

Why

A system for evaluating the effectiveness of BHC's has not been designed or tested. No BHC-specific baseline information was collected which will permit assessment of changes in morbidity/mortality. Lack of personnel to collect data and of MOPH capacity to absorb it hampers progress.

Forecast

It is probably unrealistic to expect that data of this sophistication can be collected during the life of the project.

Recommendations

1. In view of the heavy demands for data collection being placed by BHS project on MOPH systems, total project data requirements should be reassessed. The MOPH and MSH must address the problem not only of collection, but also of analysis.
2. Agreement on the minimal essential data components in the BHS program should be reached and the collection and analysis of the data undertaken.
3. Personnel responsible for data collection and analysis in the program should be increased and/or the capability of existing personnel should be upgraded through training.

| <u>OUTPUT INDICATOR</u> | |
|---|--------------|
| LOGICAL FRAMEWORK TARGET | JUNE 1, 1977 |
| 224 - Individual client health histories developed. | |

Current Status

This target has not been met.

Why

There is some evidence that only a small percentage of BHC clients are frequent repeaters. Clients do not always visit the same BHC. A system of client-retained health cards was tried, but proved unsatisfactory. The Department of Statistics is currently assessing record and data needs of the MOPH. Pending the outcome of this assessment, a moratorium has been placed on new data and records. There is a lack of sufficient or trained personnel to analyze existing data.

Forecast

If agreement is not reached soon on necessary and basic BHS data components, time will be lost in creating essential tools for the assessment of the success or failure of the project. Critical decisions to revise, expand, or eliminate selected features of the project cannot be made rationally. There will be increasing pressure to arrive at decisions based on subjective conclusions. This might cause significant discord among the project principals.

Recommendations (see also target 223)

1. The need for client health cards and the potential that the information that they provide will be analyzed, should be reassessed. The need for this component should be examined as part of an overall assessment of the data requirements and capabilities of the MOPH.

| | | <u>OUTPUT INDICATOR</u> | |
|---------------------------------|--|-------------------------|----------------------------|
| <u>LOGICAL FRAMEWORK TARGET</u> | | | <u>JUNE 1, 1977 TARGET</u> |
| 225 | Data to construct health "profile" of people served in a particular geographical area developed. | | |

Current Status

This target has not been met.

Why

There is as yet no basic agreement among principals as to what should constitute a "health profile". Nor does there seem to be strong agreement that such a profile is necessary. So far the BHS program has relied on assumptions and extrapolations from existing data (Kapisa Study, KAP).

Forecast

Evaluation of the BHS program may help in proving the utility of a "health profile" based on existing data.

Recommendations

See targets 223, 224.

| <u>OUTPUT INDICATOR</u> | |
|---|----------------------------|
| <u>LOGICAL FRAMEWORK TARGET</u> | <u>JUNE 1, 1977 TARGET</u> |
| 226 - Client record & summary report system developed & agreed upon early in Phase I. | |

Current Status

No client record and report system has been developed within the framework of this project. The existing system which is rudimentary pre-dates the project. Present records for WFP and polyclinic clients differ considerably.

Why

Agreement has not been reached on revising the existing system.

Forecast

Given limited MOPH resources in data collection and analysis, the existing system might prove to be adequate.

Recommendations

See targets 223, 224.

OUTPUT INDICATOR

LOGICAL FRAMEWORK TARGET

JUNE 1, 1977 TARGET

227 - Record and report system included in medical & para-medical health worker manuals and in-service training programs.

Current Status

Present record and report systems are included in manual and in-service training programs.

Forecast

Should the present system be revised, corresponding changes in the manuals and training program will be required.

| <u>OUTPUT INDICATOR</u> | |
|---|----------------------------|
| LOGICAL FRAMEWORK TARGET | |
| 228 . - BHC inspections include monitoring & retraining BHC personnel in information system operation | JUNE 1, 1977 TARGET |

Current Status

The information system which is planned in the project design has not been fully implemented. Mobile training teams who do the inspection and retraining have not yet visited all operational BHC's.

Forecast

As more components of the information system are incorporated into the BHC program, their effective use can be monitored and necessary retraining of personnel can follow as prescribed in the training manuals.

Recommendations

(See target 223)

OUTPUT INDICATOR

LOGICAL FRAMEWORK TARGET

JUNE 1, 1977

229 - Client data collection
& reporting methods
tested for AHDS models.

Current Status

This target has not been met.

Why

A simple client record system has been in effect since the initiation of the AHDS model in Sorobi. Information collected on patients seen:

1. name
2. age
3. sex
4. problem
5. treatment
6. date

However, as yet, the system has not been tested or evaluated nor has a reporting method been put into operation.

Recommendations

(See target 223)

OUTPUT INDICATOR

LOGICAL FRAMEWORK TARGET

JUNE 1, 1977

- 230 - Information system provides basis for estimating
- 1) Proportion of population being served.
 - 2) Perceptions of importance of various diseases
 - 3) Shifting patterns of disease.
 - 4) Supply system functions
 - 5) Short & long run financial planning for MOPH

Current Status

There is at present a reporting system in effect. Each BHC chief submits monthly reports and quarterly summaries to both the PHO and MOPH. These reports include the following information:

1. Number of patients treated based on polyclinic register
2. WFP clients served
3. Drugs on hand at beginning of reporting period; supplies received and expended during period; balance on hand.
4. Information as above for WFP commodities.
5. Diseases encountered
6. Malaria summary
7. TB summary
8. Smallpox summary
9. Vehicle use information.

MSH is planning a revision of this system but this has not been done.

Recommendations

(See Target 223)

| <u>OUTPUT INDICATOR</u> | |
|--|----------------------------|
| <u>LOGICAL FRAMEWORK TARGET</u> | <u>JUNE 1, 1977 TARGET</u> |
| 231 - MOPH will provide to USAID a quarterly report (no later than 30 days after the end of each reporting period) on the percentage of construction completed for each BHC. | |

Current Status

This target has not been met.

Why

The MOPH has not submitted the required reports in writing. Informal and oral reports, which do not differ significantly from those provided by USAID/CDE personnel, have been provided.

Forecast

Recommendations

1. The MOPH should be urged to submit the reports in writing as required in the project design. This report could also be useful for various departments within the MOPH.

OUTPUT INDICATOR

LOGICAL FRAMEWORK TARGET

JUNE 1, 1977 TARGET

232 - Administrative & teaching personnel of the ANM school provided in numbers insuring a teacher-pupil ratio of one to ten when the school is operating at full strength.

Current Status

Target is being met.

Why

School will be at full strength when the next class comes in (Sept. 1977) Teacher-pupil ratio of one to ten adhered to.

| <u>OUTPUT INDICATOR</u> | |
|--------------------------|--|
| LOGICAL FRAMEWORK TARGET | JUNE 1, 1977 TARGET |
| 233 | Twelve ANM faculty and full time professional/administrative personnel each receive nine months of academic training in the U.S. |

Current Status

- 1) On schedule: 13 trainees have returned from U.S. training.
- 2) Participants state that the Santa Cruz training program puts too much emphasis on Family Planning at the cost of other subjects.

Why

- 1) Schedule was slightly revised because of language problems of participants.
- 2) The ANM teachers have to teach whole field of MCH, Public Health and nursing, FP being only a small proportion of the ANM curriculum.

Forecast

- 1) English language will remain the major problem of U.S. training, but U.S. training is regarded as extremely valuable for teachers.
- 2) Training programs might have to be revised.

Recommendations

On next visit of Santa Cruz official to Afghanistan curriculum of U.S. training for ANM teachers should be discussed with teachers and officials of ANM school.

OUTPUT INDICATOR

LOGICAL FRAMEWORK TARGET

234 - 310 students admitted to 18-month ANM course of which 140 graduated by end of Phase I.

JUNE 1, 1977 TARGET

Continuing enrollment of 150 students; 50 new students enrolled each semester for the 3-semester course.

Current Status

At present two classes of a total of 120 students are enrolled in September, another class of 50 will be admitted, thus on target.

Why

Recruitment of candidates was delayed in the beginning because it was recognized too late that merely sending out letters and telegrams did not suffice to get enough qualified candidates. The enrollment has to be done on a face-to-face basis which means that a team from the school has to go out and interview the prospective candidates in their villages. After this procedure was established no further delays occurred.

Forecast

In September 1977 the ANM school will have the full enrollment of three classes of 50 students each.

Recommendations

None

| <u>OUTPUT INDICATOR</u> | |
|--|---------------------|
| LOGICAL FRAMEWORK TARGET | JUNE 1, 1977 TARGET |
| 235 - Participants trained for the ANM school return to full time faculty or administrative positions in the ANM school on completion of their training in the US. | |

Current Status

Thirteen trainees have returned from U.S. training. To date only one has dropped out of the program.

Why

One trainee, though successful in her studies, chose for personal reasons not to work in the ANM school, but went to a BHC.

OUTPUT INDICATOR

LOGICAL FRAMEWORK TARGET

JUNE 1, 1977 TARGET

- 236 - AHDS models designed & tested to provide answers to following questions:
- 1) Can AHDS workers be recruited, trained & motivated to deliver services which are effective & accepted by the people?
 - 2) Can viable purchase, pricing and cash/materials systems be developed & sustained at AHDS levels?
 - 3) Are training & supervising designs adequate?
 - 4) Are the services selected for AHDS trials the most important & acceptable to the people?
 - 5) Are other delivery agents more likely to be accepted than those chosen for Phase I AHDS models?
 - 6) Do the results of the pilots justify either further trials or a phased expansion for the whole nation?

Current Status

Two AHDS models, one in Sorobi utilizing 11 village health workers and one in Girishk, employing 11 dais, have been designed and have been functioning for a short time. The systems have been designed to have optimum impact with minimum diversion of limited MOPH resources. The program has been initially well received by the target population. However, the status of this target cannot be fully assessed at present.

Why

The AHDS models have not been operating for a sufficient length of time to make assessment feasible.

Recommendations

1. Evaluation of the models, which will make possible the objective assessment of the AHDS program, should be conducted as planned.

ASSUMPTION SCOREBOARD

PURPOSE TO GOAL

1. The MOPH will provide continued manpower and budgetary support to its rural, preventive health care program.
2. Donor assistance to MOPH programs will, as a minimum, be maintained at currently planned levels.
3. GOA places a high priority on the provision of expanded public health services.
4. Epidemics are contained.
5. No major food shortages occur.

OUTPUT TO PURPOSE

1. The MOPH will provide from its ordinary budget in this and subsequent years sufficient funds for the recurring costs of operating at an agreed minimal level the BHCs financed in the Phase I project.
2. The MOPH will assign graduates of the ANM school, upon satisfactory completion of the full course, to BHCs for a period of not less than two years and ____ % of these graduates will remain at assigned BHC for at least two years.
3. Villagers will be more likely to accept services and education from persons known to them.

| | Proved Valid | Unproved | Proved Invalid | Critical |
|---|--------------|----------|----------------|----------|
| | | X | | X |
| X | | | | X |
| | | | X | |
| X | | | | |
| X | | | | |
| | | X | | X |
| | | | X | X |
| | X | | | |

INPUT TO OUTPUT ASSUMPTIONS

1. BHS institutional and personnel motivations are sufficient to sustain required effort.
2. Villagers receptive and willing to participate in AHDS model(s).
3. MOPH implements rational medicine/drug policy and insures inventory levels at BHCs.
4. The MOPH will be able to make whatever administrative changes may be necessary to meet project objectives.
5. The MOPH will designate 7 officials qualified by education and experience to serve as counterparts to the USAID provided expatriate advisory personnel.
6. The MOPH will nominate qualified MOPH employees for project training abroad.
7. Qualified candidates for all targeted BHC positions are available.
8. Currently inadequate English language capabilities of participant training candidates can be sufficiently improved by special language programs to meet participant training schedule.
9. Estimated unit costs of BHCs will not exceed those stated in Project Paper.
10. Construction of BHCs begins not later than 60 days after site selection.
11. Practical survey instruments can be developed and implemented by Afghan interviewing teams and can be planned, conducted and analyzed within less than six months at reasonable cost.

| | Proved Valid | Unproved | Proved Invalid | Critical |
|---|--------------|----------|----------------|----------|
| | | X | | X |
| | X | | | X |
| | X | | | X |
| | X | | | X |
| | | | X | |
| X | | | | X |
| | X | | | X |
| | | | X | |
| | | | X | X |
| | | | X | |
| | | | X | X |

INPUT TO OUTPUT ASSUMPTIONS (continued):

- 12. UNICEF contributions to project operations will be maintained as planned.
- 13. Other AHDS experiments will be undertaken outside of project that allows comparison of AHDS model results against other alternatives.
- 14. The MOPH will establish, within each BHC, an authorized position for a trained ANM (graduate of the ANM school) with remuneration commensurate with experience and training and customary for this category under the rules and regulations of the GOA.
- 15. The MOPH will insure adequate storage and control of and access to all USAID commodities provided to project.
- 16. The MOPH demands for services of project staff outside of project specific activities will not unduly restrict output achievement.

| | Proved Valid | Unproved | Proved Invalid | Critical |
|---|-----------------|----------|-------------------|----------|
| | X | | | X |
| | X | | | |
| X | | | | X |
| | | X | | |
| | X | | | X |

PURPOSE TO GOAL
ASSUMPTION

301 - - The MOPH will provide continued manpower and budgetary support to its rural, preventive health care program.

Conclusion

| Proved Valid | Unproven | Proved Invalid | Critical |
|--------------|----------|----------------|----------|
| | X | | X |

Reasons

The test of this assumption will come as the BHC's constructed under this project become operational. To date manpower and budgetary resources have been adequate for project needs, except for construction personnel. Without careful manpower planning, this assumption could prove difficult to realize.

Recommendations

1. USAID should provide through MSH a consultant to assist MOPH systematize its planning for future BHC manpower needs.

PURPOSE TO GOAL
ASSUMPTION

302 - Donor assistance to MOPH programs will, as a minimum, be maintained at currently planned levels.

Conclusion

| Proved Valid | Unproven | Proved Invalid | Critical |
|--------------|----------|----------------|----------|
| X | | | X |

Reasons

All indications are that donor resources are likely to remain the same or increase.

PURPOSE TO GOAL
ASSUMPTION

303 - GOA places high priority on the provision of expanded public health services.

Conclusion

| Proved Valid | Unproven | Proved Invalid | Critical |
|-----------------|----------|-------------------|----------|
| | | X | |

Reasons

1. Public health has been given less priority than other sectors including public education in the Seven Year Plan.

2. However, reasonable attention is given to Public Health:

-- MOPH ordinary budget (afs 2.9 billion during plan) represents 1.2% of total GOA development budget. But half of this budget is for hospital construction, expansion, and improvement especially in urban areas, while 20% is for BHC construction.

3. Heavy emphasis on physical construction overshadows any priority on public health services per se, but interest in expansion is implied.

4. Budget resources indicate sufficient priority is assigned to PHS for project purposes.

5. Whether sufficient priority will be accorded to making operational the 50 BHC's to be created under the project, as well as improving and expanding services in existing BHC's, remains to be seen.

Recommendations

1. Revise assumption to read: "GOA places sufficient priority on the provision of expanded public health services to achieve project purposes".

PURPOSE TO GOAL
ASSUMPTION

304 - - Epidemics are contained.

Conclusion

| Proved Valid | Unproven | Proved Invalid | Critical |
|--------------|----------|----------------|----------|
| X | | | |

Reasons

1. Major epidemics have not occurred during project implementation.
2. Should a major epidemic break out GOA at present would not be able to fight and contain disease without foreign technical and monetary assistance. Immunization programs exist to date for smallpox and BCG vaccination only. Due to lack of technical preconditions such as "cold chain" other vaccination campaigns could not be mounted rapidly.

Recommendations

Parallel with expansion of the BHS the immunization program should be extended and fully integrated into MCH services.

PURPOSE TO GOAL
ASSUMPTION

305 - No major food shortages occur

Conclusion

| Proved Valid | Unproven | Proved Invalid | Critical |
|--------------|----------|----------------|----------|
| X | | | |

Reasons

1. Since project inception no major food shortages have occurred.
2. Food shortages, especially on a regional basis, are very likely over the life of the project, based on past trends in climatic variation.

Recommendations

1. This assumption bears continual monitoring for its possible adverse impact on health status.

OUTPUT TO PURPOSE
ASSUMPTION

306 - The MOPH will provide from its ordinary budget in this and subsequent years sufficient funds for recurring costs of operating at agreed minimal level the BHC's financed in the Phase I project.

Conclusion

| Proved Valid | Unproven | Proved Invalid | Critical |
|--------------|----------|----------------|----------|
| | X | | X |

Reasons

1. No project-financed BHC's are operational yet.
2. Reference to Question 303 gives good indication that this assumption is likely to prove valid.

OUTPUT TO PURPOSE
ASSUMPTION

- 307 - - The MOPH will assign graduates of the ANM school, upon satisfactory completion of the full course, to BHC's for a period of not less than two years and _____% of these graduates will remain at assigned BHC for at least two years.

Conclusion

| Proved Valid | Unproven | Proved Invalid | Critical |
|--------------|----------|----------------|----------|
| | | X | X |

Reasons

Of the first ANM graduates only 54% were placed in BHC's. Not enough attention had been paid in the past to recruit candidates for the ANM school from BHC sites. The assumption was unrealistic since girls will not accept assignments away from their families and one has to expect dropout through marriage, career and other personal decisions. Placement of ANM's in Provincial Hospitals can still serve the overall project purpose if they are working in MCH or FP clinics of that respective hospital.

Recommendations

1. It should be recognized that placement of all ANM graduates in BHC's is an unrealistic goal.
2. MOPH should continue emphasizing enrollment of ANM candidates from BHC sites.
3. MOPH should strive to assign at least 75 percent of ANM graduates to BHC's.
4. Yearly records on placement and changes in assignments of ANM should be kept by MOPH and made available to USAID.

5. If retention rate of ANM's in BHC's proves unsatisfactory the reasons should be identified and appropriate incentives should be considered and developed.

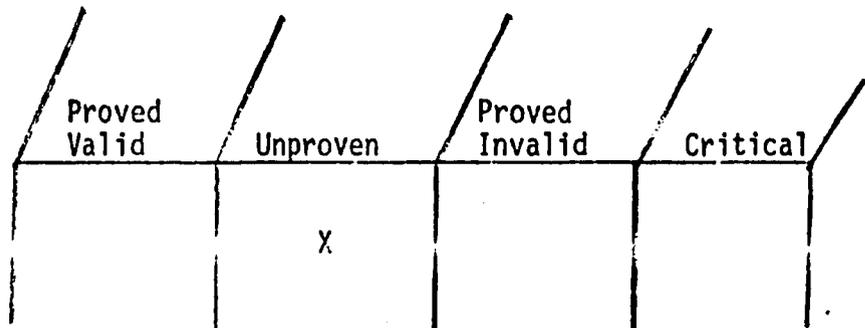
6. If an ANM is assigned to a Provincial Hospital it should be assured that she works in MCH or FP clinic.

7. This assumption should be revised to reflect the above recommendations.

OUTPUT TO PURPOSE
ASSUMPTION

308 - - Villagers will be more likely to accept services and education from persons known to them.

Conclusion



Reasons

The BHS program has not been specifically designed to test this hypothesis. No controls have been incorporated in the program to permit conclusive testing of this assumption. A priori the assumption appears reasonable. The non-availability of highly motivated and well trained personnel, who could overcome local suspicions of outsiders, is the controlling factor. Every indication is that if female personnel are to be employed in the BHC and AHDS programs at all, traditional constraints on the mobility of women require that they be from the area in which they will serve.

Recommendations

1. The assumption should be retained, but elaborate mechanisms to test it are not required.

INPUT TO OUTPUT
ASSUMPTION

309 - - BHS institutional and personnel motivations are sufficient to sustain required effort.

Conclusion

| Proved Valid | Unproved | Proved Invalid | Critical |
|--------------|----------|----------------|----------|
| | X | | X |

Reasons

It is too early to test this assumption. Prime motivational factors and their impact on the system and the individuals will have to be assessed, however, among these are:

1. Financial incentives (salary, hardship allowances and other fringes).
2. Provision of living quarters.
3. Training
4. Qualified and impartial supervision.
5. Chance for upward mobility within the system
6. Prestige.

Corrective action, should it be required, is not entirely within the scope of MOPH. The civil service system, Ministry of Planning and Ministry of Finance are also involved. Project supported incentives to increase motivation are a temporary and not wholly satisfactory solution. The GOA has exhibited reluctance to assume responsibility for project sponsored incentives at the expiration of donor involvement probably because such incentives are likely to have a negative effect on the civil service system as a whole.

Recommendations

1. Potential motivational factors should be identified and employed as a necessary lever to maintain and extend the program. This task should be included in the scope of work for a TDY manpower analyst.

INPUT TO OUTPUT
ASSUMPTION

310 - Villagers receptive and willing to participate in AHDS Model(s).

Conclusion

| Proved Valid | Unproven | Proved Invalid | Critical |
|--------------|----------|----------------|----------|
| | X | | X |

Reasons

The AHDS program is too new to permit adequate testing of this assumption. The progress of the program to date has been encouraging, but subjective views apply only to those villages served by the Sorobi BHC. Methodology for evaluation of this assumption has been designed, but it is too early for its application. Local hostility to the program has not been encountered thus far.

Recommendations

1. Testing of this assumption will be possible when the program has been established in other sites and for a long enough period to make an evaluational survey. Evaluation of both the system and individual components should be made regularly to examine any changes in villagers' acceptance over the life of the project.

INPUT TO OUTPUT
ASSUMPTION

311 - - MOPH implements rational medicine/drug policy and insures inventory levels at BHC's.

Conclusion

| Proved Valid | Unproven | Proved Invalid | Critical |
|--------------|----------|----------------|----------|
| | X | | X |

Reasons

MOPH is in the process of reorganizing drug supply and management system. At this stage the impact of these changes on the BHC level cannot be assessed. Issue No. 403 deals with the overall aspects of free drug policy.

Recommendations

Evaluation after one year.

INPUT TO OUTPUT
ASSUMPTION

- 312 - - The MOPH will be able to make whatever administrative changes may be necessary to meet project objectives.

Conclusion

| Proved Valid | Unproven | Proved Invalid | Critical |
|--------------|----------|----------------|----------|
| | X | | X |

Reasons

The MOPH has been willing to experiment with alternatives to certain existing approaches. If these alternatives prove positive they might be adopted. However, the MOPH does not have sole authority over many of the necessary changes which might make its programs more effective; i.e., reorganization, budget, personnel levels, and availability of resources etc.

Recommendations

1. This assumption bears careful monitoring.

INPUT TO OUTPUT
ASSUMPTION

- 313 - The MOPH will designate 7 officials qualified by education and experience to serve as counterparts to the USAID provided expatriate advisory personnel.

Conclusion

| Proved Valid | Unproven | Proven Invalid | Critical |
|--------------|----------|----------------|----------|
| | | X | |

Reasons

Both MOPH and BHS are aware of the requirements for counterparts. Formal counterpart relationships have not been established for all MSH personnel. MSH has not felt that the lack of counterparts is an issue. It has permitted the group certain flexibility to expand their relationships within the Ministry. Informal but adequate working relationships have thus evolved.

Recommendations

1. The need for counterparts should be reassessed. The rationale for counterparts should be explored. Will the team leave sufficient residual of expertise in management without a formal counterpart system?
2. It is recommended that if a USAID engineer is assigned to provide technical assistance to the MOPH construction division that he be assigned a counterpart.
3. If there is no mutual benefit to be gained from further counterpart assignment, this assumption should be dropped.

INPUT TO OUTPUT
ASSUMPTION

314 - The MOPH will nominate qualified employees for project training abroad.

Conclusion

| Proved Valid | Unproven | Proved Invalid | Critical |
|--------------|----------|----------------|----------|
| X | | | X |

Reasons

1. All participants selected have had relevant educational backgrounds and generally occupied project related positions.
2. Only problem has been finding qualified candidates who also have English proficiency and/or aptitude.

Recommendations

None

INPUT TO OUTPUT
ASSUMPTION

- 316 - - Currently inadequate English language capabilities of participant training candidates can be sufficiently improved by special language programs to meet participant training schedule.

Conclusion

| Proved Valid | Unproven | Proved Invalid | Critical |
|--------------|----------|----------------|----------|
| | | X | |

Reasons

1. Candidates have not been available for language training for long enough periods before departure for training, as they could not be spared from work.
2. Established USAID language requirements for participants have been consistently waived for MOPH candidates so as not to delay schedule unduly.
3. English language aptitude of many candidates has been low.

Recommendations

1. A more specialized intensive language program with experienced native speaking teachers should be considered for MOPH for participant training candidates in order to accommodate training and work requirements rationally during office hours.
2. Third and in-country training opportunities should be taken wherever possible, since English requirements may be less demanding.
3. Participant training schedule should be reviewed and revised if appropriate to account for language difficulties.

ASSUMPTION

3:7 - Estimated unit costs of BHC's will not exceed those stated in project paper.

Conclusion

| Proved Valid | Unproven | Proved Invalid | Critical |
|--------------|----------|----------------|----------|
| | | X | X |

Reasons

1. Costs estimates in PP underestimated latest CDE cost estimates by 52% on average. CDE estimates are more accurate and account for inflation in cost of labor and materials.
2. Dollar/afghani rate declined some 28% which further reduced amount available for FAR.
3. All possible savings effected from downgrading of four Rank II's to Rank III's.
4. Additional savings as well as quicker construction could be effected by shifting from stone construction to brick on some BHC's in the South where work has not yet begun.
5. This issue has contributed to delays in signing LOU No. 2 and to MOPH doubts about CDE estimating procedures.
6. USAID has been forced to reduce its intended FAR contribution from 75% to 59% of total direct construction costs.

Recommendations

1. AID/W should approve USAID's ABS request for increased funding to raise FAR contribution on nine BHC's underway to originally intended 75%.

2. To permit accurate calculation of funding requirements for next project agreement. MOPH and USAID engineers should agree immediately on cost estimates.

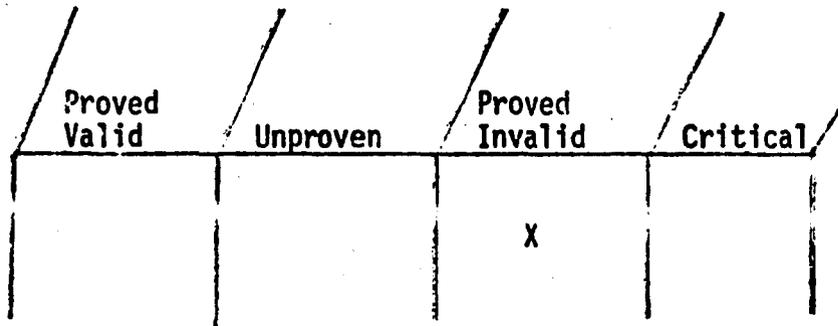
3. In the event no agreement is reached, USAID should proceed on the basis of its own cost estimates.

4. Consideration should be given to shifting to brick where appropriate.

INPUT TO OUTPUT
ASSUMPTION

318 - Construction of BHC's begins no later than 60 days after site selection.

Conclusion



Reasons

1. Nine sites were originally selected in the South. Only five BHC's are actually under construction. Additional sites have been selected in the North. Only two BHC's are actually under construction.

2. As described in 204, delays in locating contractors along with shortage of MOPH engineering staff have made this assumption difficult to realize.

3. Realization of this assumption will help adhere to planned construction schedule, but 60 days is fairly arbitrary especially when many sites are selected at once and few contractors are available to start work.

Recommendations

1. MOPH should not allow contractors to get overextended in order just to realize this assumption.

INPUT TO OUTPUT
ASSUMPTION

- 319 - - Practical survey instruments can be developed and implemented by Afghan interviewing teams and can be planned, conducted and analyzed within less than six months at reasonable cost.

Conclusion

| Proved Valid | Unproven | Proved Invalid | Critical |
|--------------|----------|----------------|----------|
| | X | | X |

Reasons

Surveys have been designed and conducted for BHC and ADHS site selection, ADHS personnel selection, and mobile training evaluation. BHC and ADHS performance evaluation instruments have yet to be designed and utilized. Pre-implementation analysis has been conducted, but anticipated systems for analysis of program performance (especially BHC) are not in place. Data collection seems to be less problematical than data analysis and data use. There are not sufficiently trained personnel to analyze, or sufficient demand to require the timely analysis of, program performance data. See also target 223

Recommendations

1. Optimum data needs of the MOPH should be reassessed. Continuation or expansion of the program should be contingent on analysis of present performance.

INPUT TO OUTPUT
ASSUMPTION

320 - UNICEF contributions to project operations will be maintained as planned.

Conclusion

| Proved Valid | Unproven | Proved Invalid | Critical |
|--------------|----------|----------------|----------|
| | X | | X |

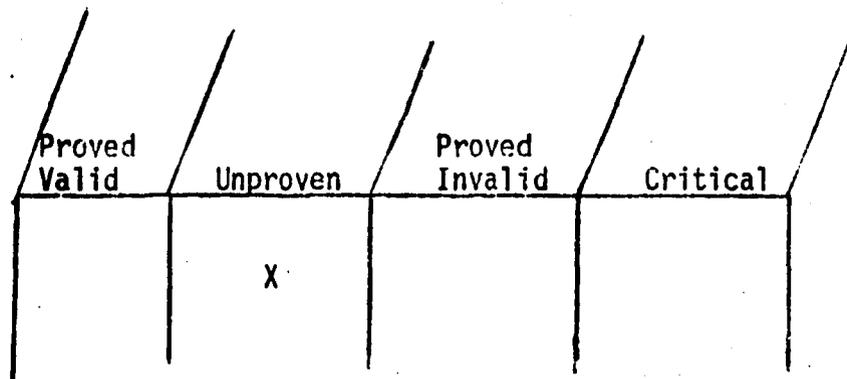
Reasons

1. UNICEF is in the midst of revising its assistance plans.
2. No information was obtained on the nature of these plans.
3. UNICEF assistance is critical, especially in the area of drug supply.

INPUT TO OUTPUT
ASSUMPTION

321 - Other AHDS experiments will be undertaken outside of project that allows comparison of AHDS model results against other alternatives.

Conclusion



Reasons

An AHDS model was established in Sorobi in mid-May. A second model is planned for Jaghori and will be in operation in late summer. An alternative to the above models, the dai program, was established in Girishk in June. Each of these programs was developed within the framework of the MOPH with MSH assistance and support.

The Rural Development Department has functioning health delivery programs centered in Chardeh Ghorhand and Katawaz. These, however, are more closely comparable to the BHC's, and do not provide the decentralized resident services which are a feature of AHDS.

Recommendations

1. No comparisons of AHDS with models outside the MOPH need to be made, since the diversity of models within the project will permit effective evaluation. This assumption should be dropped.

INPUT TO OUTPUT
ASSUMPTION

322 - The MOPH will establish, within each BHC, an authorized position for a trained ANM (graduate of the ANM school) with remuneration commensurate with experience and training and customary for this category under the rules and regulations of the GOA.

Conclusion

| Proved Valid | Unproven | Proved Invalid | Critical |
|--------------|----------|----------------|----------|
| X | | | X |

Reasons

MOPH has established position of ANM within BHC's on contract basis.

Recommendations

MOPH effort should be continued to define position of ANM within GOA personnel system. The possibilities for incentive purposes of funnelling ANM's into the civil service after a certain number of years of service should be discussed and/or other incentives introduced (see also 307). Similar consideration will have to be given to the position of other less trained females who will be working in the BHC's where no ANM's are available.

INPUT TO OUTPUT
ASSUMPTION

323 - The MOPH will insure adequate storage and control of and access to all USAID commodities provided to project.

Conclusion

| Proved Valid | Unproven | Proved Invalid | Critical |
|--------------|----------|----------------|----------|
| | | X | |

Reasons

1. While storage and control of USAID supplied contraceptives has been good, access to these commodities is encumbered by the need for numerous signatures to obtain their release from storerooms. This is standard GOA practice, however.

2. Control and access to 26 USAID supplied vehicles for project purposes has been unsatisfactory. MOPH has failed to comply with Project Agreement provision to account for these vehicles, and unofficial accounting indicates that some vehicles have been diverted to non-project related activities.

Recommendations

1. MOPH should provide USAID with official account of 26 vehicles supplied for project activities.

2. If vehicles have been diverted, they should be reassigned to project activities.

INPUT TO OUTPUT
ASSUMPTION

- 324 - The MOPH demands for services of USAID provided project staff outside of project specific activities will not unduly restrict output achievement.

Conclusion

| Proved Valid | Unproven | Proved Invalid | Critical |
|--------------|----------|----------------|----------|
| | X | | X |

Reasons

The project design anticipated that about 10% of MHS staff time would be spent on non-project activities. Demands of the MOPH have exceeded this percentage, but the MSH staff feels that the results of time spent on other activities has helped to cement relationships with MOPH. It has apparently not worked to the detriment of most project activities. Nevertheless, there is an incipient morale problem in the excessive over time which the staff must work.

Recommendations

1. This assumption requires monitoring. Both the MOPH and MSH must realize that project objectives are of primary importance. Restrictions on the use of MSH staff time need not be made if project objectives are being met in a timely fashion.
2. However, USAID should make it clear to both MSH and MOPH that, should future circumstances warrant, MSH may be required to place heavier concentration of staff time on project activities or reassess staff size.

Issue 401 - Efficacy of FAR

Conclusion

FAR has not enabled the MOPH to meet construction targets of the project. As a result, no funds have been transferred under FAR to date.

Reasons

1. MOPH lacks construction management and implementation capabilities which cannot be developed simply with financial or performance incentives.

2. FAR's incentive to MOPH is less financial, since money goes to Ministry of Finance and is unrelated to MOPH budget allocation, than performance oriented. Since FAR serves to highlight weaknesses in performance, Ministry officials may press for better performance to avoid embarrassment.

3. USAID monitoring engineers have had to devote considerable time and energy to providing technical assistance to expedite construction while maintaining quality standards contained in specifications and drawings for BHC's. This was not foreseen under FAR approach, but has been necessary to make up for management and implementation weaknesses.

4. MOPH has been more concerned with accelerating construction than adherence to drawings and specifications. This has coincided with contractor's own traditionally more casual attitude about construction quality and cost savings concerns, putting USAID engineers in the difficult position of forcing adherence to drawings and specifications.

Recommendations

1. FAR should be recognized as a useful device for highlighting specific managerial and implementation deficiencies and as a convenient financing procedure which provides ultimate insurance against USAID paying for BHC's which are faulty in construction or inoperative. FAR alone should not be expected to develop capacities where none exist.

2. In order to accomplish project construction targets, USAID should consider providing technical assistance to help MOPH directly in improving its effectiveness and reducing the monitoring demands placed on USAID/CDE.

Issue 402 - Effect of WFP program in BHC MCH Services

Conclusion

The WFP program undeniably attracts greater numbers of people to BHC's, but its potential for expanded MCH services appears underutilized.

Reasons

1. Based on BHC's visited, on a normal day a BHC can expect 50 patients whereas on food distribution days (usually twice a week) it can expect 150-200.
2. WFP program, through the child weight card system, is able to increase provision of MCH services to women and children who might not otherwise visit the BHC if it were not for the food.
3. There appears to be no nutrition education connected with the WFP program.

Recommendations

1. WFP and MOPH should take advantage of the upcoming WFP evaluation to review the potential for expanding WFP impact on MCH services, especially in the area of nutrition education.

**Issue 403 - Provision of Free Drugs & Contraceptives to BHC and AHDS
Clientele**

Conclusion

The general policy of free drugs by MOPH is a fact but has not been fully implemented.

Reasons

1. Actual shortage of drugs in all BHC's leads to the practice that the physician in the center prescribes the available drugs to the patients who then purchase them at the local pharmacy. GOA supports this practice by licensing a pharmacy near each BHC site.

2. The Parwan study showed that in fact people spend a sizeable amount of money for drugs.

3. VHW's in the current pilot project do collect a small fee for the drugs they give out and there is no obvious objection from villagers to this practice.

4. If supply of drugs to BHC's were based on actual need and the "free drug" policy were fully implemented, quantities of drugs given out and costs might escalate beyond MOPH capacity in an expanding BHS.

5. Implementation of provision of free contraceptives is insured due to ample donor support.

Recommendations

GOA, over time, may have to reconsider its drug policy with a view to adopting a rational system of adequate drug supply and distribution.

Issue 404 - - Attention to specific need of nomads.

Conclusion

Nomads at present have access to and use BHC's which are enroute to or near their seasonal camping grounds. With one exception, BHC's have not been specifically located to be readily accessible to the dispersed nomadic population.

Reasons

Nomads tend to choose camping sites which are located at some distance from the concentrated settled areas which BHC's are designed to serve. Limited mobility of BHC staff and dispersement of nomadic population make mutual permanent access impossible.

Recommendations

1. A separate program to meet the health needs of the migratory population should be studied by the MOPH. If the present AHDS program is successful, it might be extended to include, on an experimental basis, a selected nomadic group.

Issue 405 - Quantity of USAID Project Staff

Conclusion

USAID Project Staff has been inadequate to date to achieve project purposes.

Reasons

1. AID/W failed to recruit a full-time project officer. Instead Health/FP Division Chief had to fill in on a part-time basis, making it difficult to monitor the project on a day-to-day basis as required to anticipate crises and resolve implementation problems as they arise. This problem is now solved with the assignment of a project officer from within USAID's staff.

2. USAID/CDE staff has been insufficient to provide one full-time engineer to MOPH to carry out monitoring responsibilities and to meet the demands for a technical advisory role. Four different engineers have worked with MOPH, which has led inevitably to discontinuities and "get-acquainted" delays.

Recommendations

i. USAID should consider providing technical assistance to help MOPH directly in improving its construction performance (see also 401 for additional rationale for this recommendation).

Issue 407 - Motivation of VHW to provide preventative care in contrast with curative care.

Conclusion

There is at present little motivation for VHW's to provide preventative services. The effectiveness of training and supervision to motivate VHW's in providing preventative services have yet to be assessed.

Reasons

The demand for curative services is greater than that for preventative care. Incentives for curative services have been incorporated into the program through token VHW profit from the sale of drugs. Other than training, there are no incentives for VHW's to provide preventative services.

Recommendations

1. The provision of preventative services in the AHDS program need careful evaluation in order to avoid the pre-eminence of curative care. The need for incentives to provide these services should be anticipated and incorporated into the program.

Issue 409 - BHC Physicians' Private Practice Conflict with Government Responsibility

Conclusion

Work of physicians in private practice is compatible with their work in a BHC and at present a necessity to booster the low government salary.

Reasons

Physician's government salary at present is too low to allow them to solely depend on it for their living expenses.

Recommendations

It should be acknowledged that at present the physicians working in BHC's are dependent on the additional income from private practice. Consider future alternatives e.g., higher salaries and/or other incentives.