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SECTOR STUDY
POPULATION/FAMILY PLANNING
PROJECT NUMBER 306-11-570-110

Kabul, Afghanistan
July 5, 1972

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PART I

SECTOR ANALYSIS AND STATEMENT OF GOAL

The population of Afghanistan, its age distribution, birth rate, death rate, infant mortality rate, average family size, and desired family size are all virtually unknown. Information has been collected at erratic intervals and unsystematically.

Population estimates range up to 17 million. The country covers 635,524 square kilometres, 6% of which is arable. The UN Demographic Handbook estimates a birth rate of 51 per 1000 population for Afghanistan, the highest birthrate cited for any country.

The most recent estimates relating to population growth rates are from the Statistical Handbook published by the Ministry of Planning in April, 1972. They estimate that national income rose 1.5% annually during the third plan while population was increasing 2.3% annually over the same period.^{1/}

Information on infant, child and maternal mortality rates is scarce. Where data are available for limited areas, such as the studies done by the Medical Assistance Program in the Hazarajat, the customs of neutral writing in government reports are difficult to observe.

During 1970, 1,622 women were questioned with regard to the number of pregnancies they had had, and the number of live births. The average number of births per mother in

1/ As translated by Caravan Translation Service, April 4, 1972.

*Some cities
(eg. Herat)
through to
have
4.600
BTR 5
of similar
magnitude*

*typical of really
backward
places -*

this group was 6.3 and the average number of living children per mother was 3.3. Of those women who had passed the child bearing age, there had been 8.6 live births per mother and 4 living children per mother or a survival rate after child-bearing is finished of 46.5%. The young women in this group had had an average of 2 children before the age of 20 of which one child had survived.^{1/}

A recent UNICEF study by Mr. Georges Celestin reports that maternal mortality "reaches about 3-5% in cities and 6-8% or more in rural areas."^{2/}

The higher and earlier mortality of women is suspected from a Ministry of Planning study of Lashkar Gah. The proportion of women of child bearing age is disproportionately small compared to the proportion of women in the total population.

	<u>Urban</u>	<u>Rural</u>	<u>Total</u> ^{3/}
% women in total population	44	47	46
% women in total population of age 35-44	25	40	37

Heavier male immigration to urban areas may account for women age 35-44 being only 25% of all population of that age in urban areas, but the disproportionate sex ratio among rural adults is a likely measure of high maternal mortality.^{4/}

1/ 1970 Annual Report of the Medical Assistance Program, Afghanistan, p. 40.

2/ Celestin, Georges, Children's and Adolescent's Need in Afghanistan, UNICEF, November, 1971, p. 21.

3/ Ministry of Planning, Survey of Progress 1969-70.

4/ New settlements and customary under-reporting of women are possible explanations.

The reader must not permit himself to be seduced by the trappings of statistics in this section. Estimates cited are made by knowledgeable people but are based on little solid data. Regional studies often provide clues which should be investigated or verified for larger populations. One of these is Richard Scott's study of North Shamalan Valley. He found an average family size of 10.8 members among landowners and 10.2 for sharecroppers. Nine surveys done by the Ministry of Planning in nine provinces show average family size ranging from 8-11 members.

The only study known to have been done in Afghanistan which approaches a KAP study was that done by a graduate student, Gudrun Eger, in Kabul in 1968. 324 women were interviewed in four different areas representing differing economic and educational stratas. Another 90 patients of Maternity Hospital were interviewed randomly selected from among all patients. The results show high fertility. In the age group 36-40 years, the women of all the four areas have had an average of more than seven live births.

TABLE 1

Average number of pregnancies in relation to marriage-duration

<u>Sub-District</u>	<u>Years of marriage - duration</u>					
	<u>4 and 5</u>	<u>6-10</u>	<u>11-15</u>	<u>16-20</u>	<u>21-25</u>	<u>26 and more</u>
I	2.0	<u>4.7</u>	5.8	7.0	7.0	≥9.1
II	2.0 ⁺	<u>3.7</u>	6.2	≥8.1	≥8.0	7.3
III	<u>2.8</u>	3.8	5.2	7.1	≥9.5	≥8.8
IV	2.3	4.2	<u>6.8</u>	≥8.4	≥9.8	≥10.8
<u>Hospital Sample</u>	2.8	4.1	≥6.7	≥8.4	≥9.5	≥9.7

+ = one case only...

The sign ≥ indicates that in these means women having had 11 or more pregnancies or live-births respectively are included at a value of 11, so that the actual mean might be also somewhat higher than the value given. The underlined values are the maximum values of each marriage-duration group.

The uncertainty of statistical definition of the population problem in Afghanistan makes clear the reasons why the first substantial activity in this area was a national demographic and family guidance sample survey, which is contracted to the State University of New York. The field work for this survey is expected to be completed in November, 1972.

When the Population Task Force was organized, its first challenge from the Director was: Is there a population problem in Afghanistan? Are government officials concerned about a population problem? Need they be concerned?

Without better data, it is difficult to document the population problem in Afghanistan. A population of 10 million in Afghanistan could be numerically high for available resources. Certainly, the purpose of population programs is not concern with numbers only.

Where there is an infant mortality rate which may be 200/000, and a child mortality rate which may be 500/000, where women have one chance in ten of not surviving a single birth, ^{where} an agricultural country ¹ which has imported food for the past fourteen years, where 21% of its children are enrolled in school in a country with a less than 10% literacy rate, there is a population problem. *gibberish*

In developing its Fourth Five Year Plan, the Royal Government of Afghanistan has gone another step toward defining the quality of life desired for its citizens and the prospect of resources available for its attainment. One of their ^{for what they have allocated resources?} goals, which is bolstered by resources, is the extension of health services to rural areas. The orientation of these basic health clinics is to be that of preventive medicine. But if the change is made from no medical facilities to some medical facilities, there is likely to be a corresponding change in many of the mortality rates which have been found in regional studies.

To say f.p. services should be provided at same time as better health services are made available is not to say they should be provided together may make more sense

Other development besides better health services will contribute to a lower death rate.

distribute condoms commonly, eh. look at what demand mt. be

For the first time in any country, the extension of health services, and its likely effects on population can be accompanied, not followed, by family planning services.

In order to avoid increasing the pop. gr. rate as result of ↓ DR while BK constant

With sufficient personnel, if well trained and effectively supported for their Family Health programs, Afghanistan need not experience an exaggeration of its existing population problems. In summary:

A high birth rate in Afghanistan is presently being balanced by high infant, child and maternal mortality rates.

Most development projects of consequence are likely to contribute to a lowered death rate whether agricultural production, education or health services. Therefore:

A. The sector goal aims at preventing the next step in the common sequence of events where ~~rising population caused by lower death rates~~ declining ~~death rates~~ death rates bring a sharp acceleration in pop. gr. which subverts the effects of development. The goal may be stated:

To achieve a population growth rate which is compatible with the social and economic development progress of Afghanistan.

aren't they also wanting to reduce pop gr rate below present level - not just prevent further rise?

B. Measurement of the Goal

Changes in population dynamics are necessarily slow and necessarily measured in decades. The projects outlined in this paper are planned for an initial 4-5 year period. The expectations of achievement must be moderate.

In this time frame, groundwork for a population program will be laid. By the end of this period, the concrete evidence of achievement will be in the existence of (1) harder data about population; (2) institutions to continue measuring changes of population growth; (3) family planning services available in rural counties as well as in urban areas; (4) completed experiments in commercial distribution of contraceptives; and (5) awareness among planners, educators and health officials of the implications of population growth rates.

By the end of the project, new capability should exist in the Royal Government of Afghanistan to measure changes in birth and death rates and the population growth rate. The instruments for measuring achievement toward the goal will exist. But movement toward the sector goal may not be sufficient in this period of time to make measurable difference in the population growth rate.

These might also be some "demand-side" experimentation - look at why families may want big families - what mt. be done to change their minds

just services?

haven't defined a sector

C. Basic Assumptions

There are factors outside the scope of activities which could affect the outcome of the project.

The most crucial of these is the danger that the general process of modernization and development undertaken by the Royal Government of Afghanistan may be obstructed by traditional leadership. Generalized fears that traditional values are being deserted could be focused onto the purposes of this project.

Every activity listed, KAP survey, family planning services, exploitation of commercial distribution of contraceptives, and population awareness is potentially sensitive.

Implicit in the entire proposal is a regard and argument for a change in the status of women - concern for her health, limitations on childbearing, her education in matters of maternal and child care and recruitment into employment. The concept of planning can be seen as being in opposition to "enshallah" (God willing).

We tread a slender path but the direction has been set by the Royal Government of Afghanistan. The goals and purposes of this program are derived from articulated policy or program action of the Government. The Health Fourth Five Year Plan states:

A Family Health Directorate (MCH and family planning) will be created in the Department of Preventive Medicine to cooperate closely with the BHS in planning the family health programmes to be implemented through the basic health services.

Another ameliorating factor is that the motivation for the project is concern for people. This motivation must be visible - e.g., the reason we plan for children is that we care about them.

Another assumption is that development funds and ordinary expenditures continue to be available for the gradual geographic spread of health facilities and the organization of a centralized statistical organization.

The Ministry of Planning has included in the Fourth Five Year Plan the full development budget of the basic health system. Committee hearings in Parliament have been supportive of increased health budgets for basic health clinics. The assumption is more basic. It relates to the capability of the Government to collect and ration necessary resources.

The sequence of events which contribute to achievement of the goal are not all activities covered by this proposal. The national sample survey being done with assistance from the State University of New York, and the institutionalizing of data collection in a Central Statistics Office are covered in other proposals. These projects are a part of the mosaic and contribute to a logical progression toward the population sector goal. The UNESCO projects on functional literacy and radio education are other examples.

The inputs of WHO, UNICEF and AID to this and immediately related fields have been coordinated with considerable precision. Another assumption related to the goal, is that the general level of assistance of major donors will be sustained.

A central hypothesis put forward by this project for testing has to do with the inclusion of family planning service within a family health program. This family health program includes maternal and child care, health education and family planning.

The concern of those who have observed family planning programs in other countries is that the backlog of curative needs tends to submerge family planning. It is a curious thing but curative medicine has not won its spurs in Afghanistan. There is no great rush of customers at the clinic door unless female medical personnel are available to help women and child patients.

The design of the network of basic health clinics which will be established during this Five Year Plan period is aimed toward public health and preventive medicine. The major services of a basic health clinic are:

1. Control of communicable disease
2. Environmental health
3. Family health (MCH and family planning)
4. Health education
5. Vital and health statistics
6. Simple curative medicine and first aid

The substance of our argument is that in a culture with heavy observa-
tion of purdah, one of the few ~~channels through which~~ women can be

reached is a family health approach. There is some evidence to

suggest that desired family size as expressed by Afghan women is

substantially smaller than family size desired by Afghan men. It would

seem prudent to exploit existing motivation toward limited family size.

Why not
the men?

Because there is no previous rural medical service or any reputation
or clientele established, Afghanistan offers an especially appropriate
situation for testing the results of including family planning in a family
health program as compared to a free standing family planning program
as represented by the Afghan Family Guidance Association. That hypo-
thesis could be stated:

That given severely limited resources of manpower and
resource, there will be a larger return in numbers of
family planning acceptors per unit invested when family
planning is included with maternal child health services
than when the same magnitude of investment is made in
a family planning program alone.

Evidence relating to this hypothesis will be monitored and reported
throughout the life of the project.

Why? For old-age sec.?
or religion? Because they like kids?

PART II

THE ENVIRONMENT

The previous section describes the tip of the iceberg. It is a recital of estimates and impressions which demonstrate Afghanistan's need for better information. There is movement in this field - a national sample demographic survey and a knowledge, attitude, and practice study assisted by the State University of New York (SUNY) and a more recent effort to bring together the Royal Government's data collection efforts in a Central Statistical Office.

A. Afghan Demographic Studies

The major population activity presently funded by USAID is the contract with State University of New York providing a staff of 13 Americans, equipment and budget of approximately \$500,000 annually to work with the Department of Statistics, Ministry of Planning (and its successor, the Central Statistics Office), the Ministry of Public Health, and the Afghan Family Guidance Association. This joint activity, the SUNY staff plus counterpart staff seconded by those organizations, are referred to as Afghan Demographic Studies. The two immediate tasks of this project are a national demographic sample survey in order to estimate population, and a knowledge, attitude and practice survey to determine existing fertility behaviour.

Hopefully questions will be better designed than those in some past KADS, which shed little light on desired family size etc.

The demographic study will produce benchmark data on:

1. Size of population
2. Age distribution of the population
3. Sex distribution of the population
4. Marital status
5. Rural - urban distribution
6. Size and structure of families and households
7. Level of education and literacy
8. Occupation and industry
9. Migration
10. Birth rates
11. Death rates, including infant mortality
12. Rate of natural population increase
13. Social economic status

incomes (monetary + subsistence/non-mon)

Birth rates, rate of natural population increase, and other vital data cannot be determined reliably from one point of time. Additional research will be described under activities toward the goal.

The above data are required by all government departments including the Ministry of Public Health and the Afghan Family Guidance Association. Additional family guidance information will be gathered through interviews with all married women in a sample of more than 4,000 households. In these interviews, the following topics will be included:

1. Knowledge of family guidance
2. Attitude toward family guidance
3. Practice of family guidance
4. Communication channels through which respondents hear about new ideas.

SUNY also offers technical assistance to the Afghan Family Guidance

Association in statistical reporting and evaluation and will undertake a series of other studies for the Ministry of Public Health. The first group of studies relate to AFGA:

1. The client information system in AFGA
2. Analysis of data on existing clinic records
3. Redesign and monitoring of client information system
4. Survey of attitudes of AFGA personnel toward various types of contraceptives.

A series of other special studies will include:

1. an analysis of the causes of dropouts among family planning acceptors,
2. an analysis of the potential for the commercial distribution of contraceptives. (Please see the Revised Operational Plan of June, 1972, for further detail).

B. Central Statistical Office

A second and related activity began with the arrival of the first Bureau of Census members to assist the Royal Government of Afghanistan establish a Central Statistics Office. It is expected that substantial parts of the central office and the field organization developed by SUNY will be amalgamated into the Central Statistics Office.

A Director-General of the CSO has been appointed and the new department is taking shape within the Prime Ministry. The statistical department of the Ministry of Agriculture is the first to be made an integral part of the CSO. It brings staff, some equipment and a budget of 4.4 million Afghani (\$52,680).

The Central Statistics Office has been assigned the priority tasks of developing agricultural, industrial and pricing statistics.

C. Family Planning Services

The only family planning activity in Afghanistan at present is being provided by the Afghan Family Guidance Association through its nineteen clinics. These are predominately urban and are located in the major cities of Afghanistan. An associate member of the International Planned Parenthood Federation, AFGA currently receives an annual grant of \$125,000 from that organization and commodity support, participant training and a medical adviser through USAID.

The organization and expansion of family planning services has been done without incident in a very conservative Islamic culture. Another significant achievement of AFGA is the recruitment and training of Afghan women to make home visits. The other major means of motivation is the use of lecture and films among the workers of commercial and industrial firms.

The pill remains the most commonly used contraceptive among all acceptors. During 1971, condoms were more frequently requested by new acceptors.

So why not promote
Commercial dev.?

The staff of the Afghan Demographic Studies is assisting in an analysis of AFGA records. A cursory review of clinic records reveals that 50% of clinic visitors come only once. The cost per acceptor averages \$20.00. AFGA spent 22% of its budget in 1971-2 on administrative overhead.

With the inclusion of family planning in the basic health centers of the Ministry of Public Health. AFGA has been given three functions in relation to the government program:

1. To train staff for family planning whatever the affiliation of the staff;
2. To develop public educational programs to pave the way for increasing acceptance of family planning;
3. To assess these programs and the progress of family planning in the country in order to better plan for the future.

The protocol agreeing to this cooperation has not been signed.

Table 2

USAID Assistance to AFGA

	<u>FY '71</u>	<u>FY '72</u>
Commodities	37,500	28,200
Participants	15,965	14,505
Technical Services	<u>21,900</u>	<u>13,000</u>
Total	75,365	55,705

D. Health Services

The Ministry of Public Health has drafted its Fourth Five Year Plan.

Implicit in that plan are two basic decisions:

1. Basic health clinics will be built and staffed in order to bring health services to the woleswali (county) level;
2. Family planning services will be provided in basic health units as soon as trained women paramedicals are available to staff the Family Health unit.

Beginning in 1966, the Ministry, with assistance from WHO and UNICEF, started to increase the health services available at the county level and to integrate mass campaign programs such as malaria and smallpox into Basic Health Services. Initially, the clinics were built and staffed for seven provinces. At the conclusion of that phase, a strategy review team met. Among the criteria introduced by the Ministry for the review team's consideration was Article 36 of the Afghan Constitution:

It is the duty of the State to provide within the limits of its means balanced facilities for the prevention and treatment of the diseases for all Afghans. The aim of the State in this respect is to reach a stage where suitable medical facilities will be made available to all Afghans.

The Royal Government of Afghanistan has decided that it is necessary to move toward a national program now.

A measure of the priority which the Ministry places on a basic health system is its reservation of 63% of its health development budget for



basic health clinics. As the BHS proportion of the development budget goes down in future years, its dominance of budget for operating expenses increases. The Fourth Plan schedules 70% of MOPH ordinary expenditures in 1976 for basic health clinics.

The 15 WHO advisers working in the Ministry of Public Health in Afghanistan concur with the technical judgement behind Ministry plan objectives. The WHO representative, Dr. Pierre Clement, conveyed to the Ministry an offer of WHO assistance. The cover letter states, "It is most gratifying that unanimous agreement has been reached.

"During its deliberations, the meeting has constantly kept in mind:

The obligations already entered into by your Government and WHO

The draft Health Component to the projected Five Year Plan

The basic policy guidelines enunciated by His Excellency the Minister of Public Health for the development of health service in Afghanistan

The actual real concrete possibilities for the Government to implement programs and plans."^{1/}

Later in the same document, Dr. Clement records the first objective as "To assist in establishing throughout the country, basic health services on a priority basis."

^{1/} The underscoring is added.

103 basic health clinics of the 180 projected are in operation. Some are operating in rented premises awaiting construction of buildings. Not all have their full staff or equipment.

Approximately 30 of the clinics were organized under the Rural Development Department. Another group of basic health clinics have been taken over from the municipalities. (A county or provincial headquarters town without urban connotation)

The Ministry of Planning has agreed to the following investment resources from the Development Budget for the basic health centers.

Table 3

SUMMARY STATEMENT OF SOME DEVELOPMENT
PROJECTS OF THE MINISTRY OF PUBLIC HEALTH
(Extracted from Ministry of Planning)
(In millions)

	<u>Prior to 4th Plan</u>	<u>Old Projects 4th Plan</u>	<u>New Projects 4th Plan</u>	<u>Total</u>	<u>Sources of Funds</u>
Completion of construction of basic health centers in the provinces (Woleswalis)	\$0.520 <u>.880</u> \$1.300	\$ 3.810 <u>2.700</u> \$ 6.510	\$ 2.680 <u>0.864</u> \$ 3.544	\$7.010 <u>4.444</u> \$11.454	UN Grant* RGA** Total
Completed centers	32	117	31	180	
Completion of construction of auxiliary health centers in villages	\$0.000 <u>0.018</u> \$0.018	\$ 0.000 <u>0.094</u> \$ 0.094	\$ 0.000 <u>0.660</u> \$ 0.660	\$0.000 <u>0.772</u> \$0.772	Foreign* RGA** Total
Completed auxiliary centers	0	17	173	190	

* From World Food Program.

** RGA contributions are calculated at the rate of 83.5 Afghanis to \$1.00 and are rounded-off to the nearest whole number.

As 65 basic health clinics have been added during the last three years, 77 additional clinics would seem a reasonable goal for the next five years. 11 sub-centers are operational of the 100 sub-centers proposed to be organized by 1976.

The most crucial personnel shortages are auxiliary nurse midwives and compounders.

Table 4

PERSONNEL REQUIREMENTS FOR
BASIC HEALTH CENTERS
AND SUB-CENTERS
Fourth Five Year Plan Period
1972-1976

There will be 178 Basic Health Clinics and two check posts by 1976 requiring:

	<u>1976</u>	<u>1971</u>	<u>Needed</u>
Doctors	180	93	83
Sanitarians	180	91	89
Auxiliary Nurses	178	50	128
Nurse Midwives	178	-	178
Nurses (male)	180	96	84
Compounders	178	17	161
Lab Technicians	180	25	153
Basic Health Workers	180	141	39
Adm. Assts.	180	(Unavailable)	
Drivers	178	"	
Storekeepers	180	"	

Each health center will have three to four satellite or sub-centers with an auxiliary nurse midwife and a basic health worker in attendance. The doctor visits sub-centers once a week. Of the 540 sub-centers planned,

100 will be established in this plan period.

UNICEF has agreed to equip these centers and sub-centers and to provide a vehicle for each clinic. UNICEF also provides 12 of the 18 drugs stocked in the BHC.

The budget for recurrent expenditure is presently before Parliament.

Committee hearings have so far been favorable to MOH's requirements.

Table 5

OPERATING EXPENDITURE REQUIRED
FOR BASIC HEALTH CENTERS

1972-1976

Expenditures include salaries and allowances, travel, petrol, oil and vehicle maintenance.

Basic Health Clinics: Operating expenditures for one health center - Afs. 446,360 or \$5,250.

<u>Year</u>	<u>Annual Operating Expenditures</u>	<u>Operating Centers</u>
1971	\$446,250	85
1972	614,250	117
1976	945,000	180

The Family Health portion of this expenditure is estimated at 22%. Operating expenditure for one sub-center - Afs. 53,540 or \$630 annually.

<u>Sub-Centers</u>	<u>Operating Sub-Centers</u>	<u>Annual Operating Expenditure</u>
1971	11	\$ 6,930
1976	100	63,000

The Family Health portion of this expenditure is estimated at 40%.

The major problems identified by the MOH in implementing their Plan objectives is not finance but

- training of staff
- management

Training

The Kabul ANM School opened in November, 1971, with 62 young women recruited from the provinces. The second and third courses have been recruited and will begin at six monthly intervals. An inexperienced teaching staff is assisted by one Peace Corps volunteer and another volunteer provided through the Care-Medico Nutrition grant.

The school is presently located in two rented houses furnished in part by UNICEF and in part through USAID excess property. WHO will provide approximately \$2,250 of demonstration equipment. Both classroom and living quarters are extremely crowded.

The first midwifery text has been translated into Dari through U.S. Trust Funds.

Building for the Kabul ANM School will be undertaken during the Plan period.

Other personnel for the basic health clinics will be given public health orientation at a new Central Training Center. Doctors will have one year of training; basic health workers three months.

A unit on family planning already exists in the syllabi for all health workers and sanitarians. The public health doctor presently gets 70 hours of a separate family planning unit during a 10 months course. The next phase is to integrate family planning into appropriate places of the curriculum and to assure practical training in needed skills. For example, basic health workers have among their tasks the education and motivation of village men on family planning. A teaching unit in family planning exists but the unit on health education, also needs to cover how to inform and motivate villagers on family planning.

The Public Health Institute, (from which the Central Training Center will be developed) presently trains public health personnel. The Institute also suffers from inexperienced teaching personnel.

Management

The Ministry of Public Health has been concerned for some time with its administrative problems. Officials are frank in their descriptions of administrative obstacles to implementation of their plans. UNICEF has underscored the importance of this problem area. While granting \$1.3 million for water supply, UNICEF has written in management reforms as a condition of the grant.

There have been several previous requests from the Ministry for assistance in management and several reports have been written attempting to define the problems.

Dr. A. E. Brown, WHO, wrote a report on the management needs of the Ministry of Public Health in 1971. He recommended that advisory services in management, logistics, service statistics and a training officer be sought.

A second WHO consultant, Dr. Hutchison, did an appraisal of the Ministry of Public Health's organization for planning purposes. This report covers the Planning Board, the types of information needed for planning and job descriptions of the senior ministerial personnel. The detailed "plan of administration" which was a part of the consultant's terms of reference was handled in terms of an organizational chart. The administrative processes by which tasks are accomplished and programs implemented, were not covered by those reports.

Mr. T. B. McLaughlan of UNICEF has done a similar study in vehicle and equipment maintenance. The maintenance workshop is under construction. UNICEF will finance machinery, tools, and training.

Two representatives of Management Services for Health, Inc., made a site visit in May, 1972. They reviewed administrative problems with a large group of Ministry officials, following processes such as supply and

assignment of personnel from one functionary to another. They focused their attention primarily on the Department of Preventive Medicine and, in particular, the Basic Health Services. Their recommendations have been favourably reviewed in the Ministry and form the basis for a project proposal to follow.

Family Health

At this writing both family planning and maternal child health are functions of voluntary agencies. AFGA's role has been discussed earlier. MCH is also outside the Ministry administered by the Rozuntoon Society. It has 5 MCH clinics, all located in Kabul.

One of the major changes proposed in the Fourth Five Year Plan is the organization of a Family Health Department in the Ministry and the inclusion of family health in government health facilities: hospitals, urban clinics and the basic health services.

Family Health includes maternal child health, nutrition, health education and family planning. It will first be started experimentally in the clinics of the Afghan Women's Society in Kabul and Children's Hospital, an Indian-assisted project. With this experience, supervisory teams will be established in four provinces prior to establishing Family Health units in the basic health clinics of those provinces. The chosen provinces have female personnel through the American and German Peace Corps.

A WIIO adviser (MCH) is in position and her counterparts (both doctors and nurse midwives) are being recruited. The World Food Program provides supplementary foods for pregnant and nursing mothers and infants at the age of weaning.

Medical Assistance Program

The Ministry of Public Health has contracted with an international voluntary agency, MAP, to provide medical services in Central Afghanistan. It is a desolate mountainous area called the Hazarajat with a population estimated at two million. Compared to the current economic resources and potential, it is also the most over-populated region of Afghanistan.

MAP has established a 40 bed hospital and two of five planned clinics. Each clinic is the equivalent of a government basic health clinic in terms of area and population to be served. Two additional clinics will become operational in the summer of 1972. MAP receives a small annual grant from AID/W to subsidize 10 nurse midwives and the inclusion of family planning in their program. One of the great benefits of this grant is that it provides an experiment in family planning in the framework of a public health program for both MOH and USAID appraisal. The reporting from the Medical Assistance Program and continuing evaluation are needed on a more timely basis so that its experience is available to the Ministry prior to implementing a national program.

E. Previous USAID Assistance

Training of participants and some consultant services have been provided to the Medical Faculty at Kabul University. Since 1970, five participants from the Faculty have received scholarships and approximately two man months of consultant services. Similar assistance has been given to the Zoishgah Maternity Hospital for ten participants and approximately three man months of consultant service.

Short-term assistance and excess property have been given the Nursing Division of the Ministry and nursing schools.

Commodities in the amount of \$13,000 have been made available to the Afghan Film Agency. These commodities will be used for dubbing local language narratives on 16 mm family planning films.

Two religious leaders have been sent in 1970 as participants to Cairo, Ankara and Tehran to observe family planning activities with their counterparts and discuss Muslim policy on the subject. AFGA continues to have the active support of religious leaders.

USAID assistance to AFGA was discussed earlier.

F. Other Assistance From Other Donors

For more than 15 years WHO has assigned 15-20 advisers to the Ministry of Health. It is the premier agency in health planning and education.

For the plan period WHO continues assistance to:

1. Orientation and in-service training in
 - a. Health Education
 - b. Public Health
 - c. Environmental Health
 - d. Nursing
 - e. Laboratory staff
 - f. Health Statistics
 - g. Medical Recording
 - h. Malaria
 - i. X-ray technicians
 - j. Immunization
 - k. Tuberculosis

2. Advisory services in:
 - a. Senior Medical Officer (Basic Health Services)
 - b. Public Health Nursing Adviser
 - c. Nurse Education Adviser
 - d. Health Statistics Adviser
 - e. Public Health Administrator
 - f. Epidemiologist
 - g. Pharmaceutical quality control analyst
 - h. Sanitary Engineer
 - i. Others unrelated to this sector

Of special interest is a WHO sponsored study of infant and child mortality where cohorts of

- 1000 pregnant women
- 1000 infants
- 1000 children age 1
- 1000 children age 2, etc.

will be followed for one year.

UNICEF, too, has a long and major association with health services in Afghanistan. It has been a major donor in malaria eradication, and water supply.

UNICEF support to the basic health clinics and ANM training has been cited throughout the report. It is a major donor to the basic health clinics providing nearly \$350,000 annually (equipment, medicines and vehicles). Among new UNICEF projects is assistance to the Transport and Equipment Maintenance Organization (TEMO) for both vehicle and medical apparatus repair. UNICEF will supply an adviser and \$20,000 of equipment for TEMO.

Another newly financed project arises from the Celestin report and provides for research to "clarify the needs of children in rural areas and the possibilities for modernization and effective coordination of services for children." This study will be sponsored by the Ministry of Planning.

UNESCO supports two projects which could be related to population activities. The first is functional literacy, where family health information is included in adult literacy programs.

The Afghan sponsors of the program include the Afghan Women's Society, the Afghan Family Guidance Association, the Ministries of Public Health, Education and Agriculture. Some of the stimulus came from two World Education, Inc. Seminars. Further complementary assistance has been requested from WEI.

UNESCO and UNICEF also support a project of teacher training through radio broadcasts. Advisory services, a radio broadcast unit and 12,000 receivers have been provided.

UNFPA representatives have made four short visits to Afghanistan in order to explore possible areas of assistance. They have been asked to provide a Population officer for the UNDP staff in Kabul to coordinate UN activities in this field.

The most recent survey was done by the esteemed Dr. Gade who recommended a post partum program to be begun at Zoishgah Maternity Hospital. USAID has helped to pave the way by a substantial participant training program for Zoishgah personnel. The director of Kabul's only maternity hospital is also the president of AFGA.

The German Peace Corps will provide ten nurse-midwives to work in basic health clinics on a pilot basis. If successful, other German volunteers may be recruited. The American Peace Corps has placed four nurses in AFGA clinics.

PART III

ACTIVITIES TOWARD THE GOAL

Afghanistan is confronted with a population problem which is little appreciated and hardly defined. There are glimpses of it but no frontal measurements. Partially seen are high birth rates, an estimated population growth rate of 2.6% and cruelly high mortality rates, which will be affected as epidemics get more organized attention and midwifery and child health services become more widespread.

How should Afghanistan be encouraged to deal with population?

The most immediate need would seem to be better definition of the problems and, therefore, an investment in demographic research to follow-up on the national sample survey and studies of attitudes and fertility behaviour for surer planning of future programs.

Secondly, the channelling of family planning services into basic health services. The basic health clinics will be built and staffed. That is no longer open to decision on the part of the Royal Government of Afghanistan. The question is "Is it in the best interests of Afghanistan to have family planning services included in that structure?" What are the alternatives? A separate government family planning program and structure in a country which is preoccupied with building its rural health infrastructure and which is already financially pressed? An extension of

Why not
more
commercial
distri?

A FGA clinics which are totally subsidized by foreign resources?

Major reliance on commercial distribution? By-pass family planning services for other social development usually correlated with lowered birth rates?

It is the considered judgement of this Mission that the smallest expenditure of time and money to reach the largest potential of people would be to exploit existing systems such as basic health services.

Great concern has been expressed about the Royal Government of Afghanistan's capability to finance the expansion of the basic health clinics.

The stringent resources and capacity to manage more programs are precisely the reasons why there can be only one system for health care delivery including family planning and including smallpox, malaria and other campaigns which international agencies have tended to urge on Afghanistan in segregated systems each with its own elaborate field staff. And inclusion of family planning among the standard procedures of treatment in all government medical facilities offers a legitimization of family planning which is crucial in an Islamic country.

If family planning services are to be made available through the basic health clinics, it means an expansion from 19 A FGA clinical outlets to

300* in a relatively short time. USAID is then confronted with the

* 180 BHCs + 100 subcenters + 19 A FGA clinics

W

yes

decision as to what would be the most potent but selective inputs which could increase the effectiveness of family planning? This selection has been made in conjunction with the RGA and the UNICEF Representative, as the international agency most involved with the basic health system.

That decision is to contribute:

1. contraceptives and medications required for possible side effects;
2. training with greatest emphasis on
 - a. female paramedicals
 - b. public and family health orientation for doctors and basic health workers.

These two activities are clearly related to USAID's directives regarding use of population funds. The third area of management will provide the wheels so that plans can be implemented, services can be delivered and supplies and personnel arrive when and where needed.

These are the immediate and pivotal areas of requested assistance to which USAID intends to be responsive. There are others. The need for alternatives sent the Population Task Force exploring the potential of commercial distribution of contraceptives: what is presently available, volume of sales, distribution channels and the role of the pharmacist as counsellor. An initial survey is underway now by Dr. Russell Stone of SUNY. On the basis of this survey and others on marketing in Afghanistan, field experiments will be designed.

There were other areas considered by the Population Task Force (an interdisciplinary advisory committee organized within the Mission). Afghan government officials, especially those with responsibility for planning, need access to data on Afghanistan's population growth rate and to understand its implications to their development efforts. There is no sub-project on population awareness. It will be an activity and responsibility, however, of all concerned with population: USAID officials, SUNY, CSO, the management advisory team and other contract groups whether in administration, education or agriculture.

The first need will be the communication of the national sample survey results. Out of this survey, more cogent efforts at planning for greater population awareness will be possible.

There are other avenues to be explored: status of women, voluntary agencies, population education, indigenous practitioners of medicine such as hakims and midwives and the potential of incentives. These will be explored over time and as our definitions sharpen so will our understanding about their potential and appropriateness for Afghanistan.

One of the most notable areas of omission in the following description of activities is the field of public information, education and motivation. The Afghan Family Guidance Association has organized a small effort in information and motivation. The organization is also charged with

the responsibility for such communications programs nationally and especially in relation to the family planning services included in Ministry facilities. This larger program has not yet been designed. The most immediate resources are the SUNY researches and field experiments which will be directed at how do we increase the number of family planning acceptors. Here again, it is a matter of timing. Following evaluation of AFGA experience, some SUNY field experiments, watching UNESCO experience in school broadcasting, rapprochement between Ministry and AFGA on motivational campaigns, more concrete planning can be done and the role of international agencies be defined.

The preceding discussion was intended to illustrate the rationale in the selection of the following activities. The reader is reminded that the sector goal is:

To achieve a population growth rate which is compatible with the social and economic development progress of Afghanistan.

The activities planned to reach this goal are:

Activity 1.

Institutionalize an information system which will provide demo-graphic data over time and to institutionalize research on activities which may affect fertility behaviour. Both activities will also provide concrete measurement of achievement toward the goal.

Activity 2

Facilitate the provision and training of personnel for family planning services.

Activity 3

Provide management consultant services for an expanded family health component of basic health services.

Activity 4

Provide contraceptives for free clinical distribution and investigate alternative distribution through commercial channels.

Activity 5

Encourage population awareness through existing channels and projects.

Activity 1(a) - Demographic Research

The demographic research activity builds upon the National Sample Survey to be conducted by Afghan Demographic Studies (SUNY). That survey will serve as a benchmark and will provide demographic characteristics of the Afghan sedentary population. Other events will be recorded over a one year retrospective period and will probably be subject to a substantial degree of error.

There is a need to develop a system of data collection which will measure change over a period of time. This would make reasonable population projections possible and provide a basis for evaluating the effects of the modernization process. The civil registration system of

Afghanistan cannot now, or in the foreseeable future, be used to determine vital rates.

A solution would be to develop estimation procedures on a sample basis through the newly created Central Statistics Office. Such a program would provide a basis for developing the type of series needed to measure changes in fertility and in growth rates, at reasonable costs and within a reasonable time frame. The time frame would involve a minimum of four years before a dependable system would be in operation.

Such a system would involve a set of sample registration areas to which "registrars" would be appointed to record birth and death events continuously. The sample areas would be so selected as to provide a national estimate, with an urban and rural break. These same sample areas would be surveyed periodically through an independently run household survey. Differences between the sample registration system reports and the household survey reports would provide a correction factor based on the simple probability model developed by Chandrasekar-Deming.

FY '73 will be preoccupied with the National Demographic Sample Survey, the organization of the Central Statistics Office and its initial assignment of agricultural and industrial statistics. Concurrently, the sample survey demographic experience will be utilized both for its data and organizational experience. After the first CSO organizational phase of absorbing the statistical units of a number of ministries

including Afghan Demographic Studies, more concrete planning will need to take place on how to build the demographic capability of CSO. Neither the Bureau of Census nor CSO is now funded for that activity.

FY '73

1. Organization of CSO
2. Planning a demographic section

FY '74

1. Amend contract with Bureau of Census to provide 2 PASA professionals and 2 interns for a minimum of four years.
2. CSO recruitment of "registrars" to initiate a sample system of vital registration.

The success of this proposal will be determined largely by the ability of the CSO to train, utilize, supervise and adequately control its sample "registrars" and the enumerators employed in the household survey.

Activity 1(b) - Research in Fertility Behaviour and Motivation.

This activity refers to the existing SUNY contract Demo-KAP-306-11-570-110.2.

The first step in this research is the analysis of the present situation in fertility attitudes and behaviour in Afghanistan. The information for the analyses will be obtained from several sources, including:

1. Demographic data from national survey.

2. Detailed pregnancy histories obtained in national survey.
3. Survey of attitudes, knowledge and behaviour of women toward fertility and family planning. (Also part of the national survey).
4. Review of existing clinic records to determine characteristics of acceptors and drop-outs and to determine the effectiveness of the clinic approach to family planning.
5. Special studies of the role that the market place is currently playing in the distribution of contraceptives and the potential that it has in the future as a disseminator of information and goods.
6. A survey of the attitudes, knowledge and behaviour of clients coming to the clinics on an initial visit.
7. A survey of the knowledge and attitudes of RGA personnel toward various types of contraceptives and the distribution of contraceptives in the clinics.
8. A follow-up study of clients using family guidance services to determine characteristics of drop-outs and continued users.

Upon completion of this phase of research it should be possible to isolate the important variables affecting family planning. It will then be possible to design a series of field experiments that will investigate the causal nature and magnitude of these relationships. With these relationships defined and quantified, studies will be undertaken to alter behaviour patterns in the direction of greater acceptance of family planning services.

The time table for this work to the end of the present SUNY contract in January 11, 1974 has been charted in an attachment to the Revised

Operation Plan. It calls for

Sept.	1972	Field work national survey
Jan.	1973	Begin analysis
June	1973	Population analysis complete
Sept.	1973	Final report demographic study
July	1972	Report on client information system in AFGA complete
July	1972	Preliminary report data on existing clinic record cards. Redesign clinic information system* KAP Survey AFGA Personnel*
August	1972	Preliminary survey on potential markets for contraceptive distribution
Sept.	1972	Design study market system
August	1973	Study of distribution channels in Afghanistan completed. Field experiments in motivation*

By January, 1973, negotiations to renew the SUNY contract should be underway.

*Dependent on additions SUNY staffing pattern

Activity 2 - Training Personnel for Family Planning Services

This activity includes the pre-service training of female paramedicals, the auxiliary nurse midwife, and the public health and family planning aspects of the training of basic health doctors and the basic health worker (male village motivator and educator).

a. Auxiliary Nurse Midwives

The training of female paramedicals is of greatest urgency for without them no extension of family planning services is possible. More than 280 auxiliary nurse midwives need to be trained and retained in service for the immediate posts within the basic health services. It is intended that a second ANM be posted to each clinic as soon as they are available, making 460 trained ANMs the ultimate goal. The first class of 62 is expected to graduate in June, 1973.

The difficult task of recruitment of young rural Moslem women is going remarkably well. Almost all other factors which are important to the development of an educational institution remain to be done:

1. training of instructors
2. development of a job-related curriculum
3. development of physical facilities
4. development of field practice training

The most immediate action will be the training of the ANM tutors. A Nurse Education Adviser is required in July, 1972, to start training the tutors who are presently in position. This workshop will have the goal of preparing them for the second semester's teaching.

The next step is a three months trainers workshop for a larger number of potential nurse educators recruited from local hospitals. Follow-up activity will include observation and conferences with tutors in the ANM schools, and continuing cooperation with the Nursing Division and tutors in the development of curriculum and training materials.

Out of this period of training tutors, the technician, who is available only to June 30, 1973, will develop the long term plans of assistance for this activity. The Ministry has suggested and USAID might wish to consider a contractual arrangement with a U.S. mid-wifery training institution. That need hinges on whether or not three additional ANM schools are opened during the Plan period.

A future action, but necessary, is the preparation of the supervisors who will help these newly trained ANMs make a transition between school and the field. The Nursing Division with assistance from WHO and USAID Nursing Advisers will organize a four week seminar on Public Health and Family Health Supervision for the supervisors of nursing personnel in the basic health clinics.

Limited participant training will be included using the resources of the Middle Eastern countries.

Commodity assistance will include vehicles to make field practice possible, visual aid equipment, training materials and trust funds for translation and printing of texts. A grant is requested by the Ministry of Public Health to assist with the construction of

a hostel to house 200 student ANMs.

b. Central Training Center

The teaching section of the Public Health Institute will be known as the Central Training Center in the future. The public and family health orientation of doctors, and the pre-service training of compounders, sanitarians and basic health workers is the responsibility of this training center. The CTC will also administer the Kabul ANM School.

A small and inexperienced teaching staff is in place. Many of the WHO advisers, who have assignments in the Ministry of Public Health, teach the subject of their speciality.

A consultant from the American Public Health Association (AID/W funded contract) will be requested for September, 1972, to assist with the development of an integrated public health and family health curriculum for all staff assigned to basic health clinics. A unit on family planning does exist in all of these courses but no true integration.

A second training course for trainers will be organized for the staff of the Central Training Center. It will have two purposes:

1. Prepare the staff to teach the prepared curriculum;
2. Assist the staff with a variety of training methods

- (i) demonstration
- (ii) supervision of field training
- (iii) skill training

The land for the Central Training Center has been allotted by the RGA and is under preparation. A WHO architect has completed the building plans. The Ministry of Public Health has budgeted the Afghani equivalent of \$240,000 of development funds for the building.

Vehicles, training materials and imported construction materials such as plumbing and electric wiring to the amount of \$120,000 have been requested by the Ministry.

The priority activity for participant training throughout this population sector will be trainers.

TENTATIVE BUDGET FOR TRAINING
FAMILY PLANNING PERSONNEL

Direct Hire Technicians	\$ 40,000
Participants FY '73-'74	26,000*
Commodities: transportation, training materials	60,000
Imported materials for Central Training Center	120,450
Construction Hostel ANM School for 200 Students	<u>242,199</u>
Total	\$ 488,649

*Travel not included.

Activity 3 Provide Management Advisory Services for the
Department of Preventive Medicine.

The Department of Preventive Medicine is the responsible department under which are basic health clinics and their constituent family health units.

a. Management Advisory Services

The Ministry of Public Health has laid heavy emphasis on their request for management advisory assistance to design an improved system taking into account Afghan resources and expertise. This design would focus on the structure, procedures, and information flows required to support both the operation and the management of the program. It would incorporate such requirements as:

- Basic Health Center reporting of activity and staffing, service statistics for basic health and Family Guidance operations;
- A logistics system for planning and controlling the ordering, receiving, storage, and distribution of equipment and supplies;
- A budget system allowing improved planning and control of costs and payments;
- Analysis of costs and effectiveness of alternative methods of service delivery.

A site visit has been completed by a team from Management Services for Health, Inc. (an AID/W contractor). This resulted in a draft plan which was submitted to His Excellency, the Minister of Public Health in May, 1972 and accepted by the Ministry.

The following phases of activity are proposed:

1. A decision is required as to whether or not the existing AID/W contracts can cover the activities outlined here. If not, on approval of the PROP, USAID will initiate negotiations for contract services with an appropriate organization.
2. The Systems Analysis phase of approximately three months (September-November 1972). This analysis will include careful attention to field activities and conditions, and to areas outside the Department which affect its operations and administration.
3. Based on this analysis, a management system for those needs will be designed and pilot-tested. Prior to full implementation, central training will be provided for personnel from the Ministry, and from each active Health Center. As the system is actually implemented, continued in-service training of Department personnel will be emphasized. At the same time, training materials will be developed and tested to be used in subsequent training of new personnel.
4. The basic system should be completed within three years. Over the next two years, the system would be modified and expanded as the users' capability increases.

Predominately operational in the initial stages, greater importance in later stages will be placed on the system as a management tool which supports broad program planning concerns.

Development of a system of this scope would require a team of four professionals, including a public health physician, logistics specialist, management analyst, and a training specialist. An assistant would be needed to handle project administration. Short-term technical staff would be utilized at points of peak workload.

The extensive field travel involved would require three vehicles and drivers. Office equipment would have to include adequate tools, such as desk calculators and thermofax machines for project and Departmental use.

In addition to central and on-site training of system users, a small amount of U.S. training in management would be required for key Central Government personnel who would eventually be responsible for on-going maintenance and adaptation of the system. Basic management training in Teheran should be suitable for an additional small number.

b. Transportation

In a rural health organization and in all national programs of family planning, there are difficult problems of transportation. In Afghanistan, these problems are exaggerated by difficult terrain, poor maintenance facilities and a scattered population.

UNICEF will be the major donor of vehicles and vehicle maintenance, providing a vehicle for each clinic, and advisor services and equipment for the vehicle maintenance workshop.

USAID will contribute 28 vehicles, one for each of the 28 provinces, to be used for supervision and supplies. While related to management and administration, this commodity support is separate from the contract for management advisory services discussed in this section.

Activity 4 - Provide Contraceptives for Free Clinical Distribution and Investigate Alternative Distribution Through Commercial Channels

The USAID inputs into extension of family planning services have been cited earlier as provision of

- a. contraceptives
- b. training of personnel for family planning services
- c. management advisory services

Along with the distribution of contraceptives through clinical facilities an exploration of commercial marketing channels is also planned. While at this time it is only possible to undertake a survey of what exists, it should be possible later to develop proposals for promotion of larger sales, informal training of shopkeepers and pharmacists and recording of sales.

This activity is aimed at making contraceptives available in greater volume and with greater understanding of their use.

The actions proposed are:

- a. Continued provision of contraceptives and associated drugs (iron and medications needed to reduce side-effects) to the Afghan Family Guidance Association.

b. Undertake provision of contraceptives to the Ministry of Public Health for free distribution by the Family Health unit beginning in FY '73.

c. Record keeping system and evaluation of family planning acceptors will be developed under management advisory activity.

d. Dr. Russell Stone, SUNY, arrived May, 1972, to undertake study of commercial marketing of contraceptives.

e. Subsequent studies and experimentation in commercial markets will be undertaken by SUNY under their provision for special studies in 1973.

As no family planning service is presently given through government clinics, estimates of contraceptive costs are hazardous. It is probable that there are less than 2-1/2 million eligible couples in Afghanistan. If 1973 is acknowledged as a year preoccupied with construction and staff training, then the program in terms of motivating acceptors will get underway in 1974. 5% of eligible couples should be contracepted within three years of an active program.

If these goals are to be met, contraceptives will be required in the following volume:

	<u>1973</u>	<u>1974</u>	<u>1975</u>	<u>1976</u>
Orals	\$ 24,000	\$ 60,000	\$ 96,000	\$144,000
Condoms	25,000	62,500	100,000	150,000
Foam	2,000	4,000	5,000	5,000
IUD	<u>1,200</u>	<u>2,400</u>	<u>2,400</u>	<u>2,400</u>
	\$ 52,200	\$128,900	\$203,400	\$301,400

As family planning services are starting from zero in government clinics, clearly, the best procedures would be to revise these estimates both for acceptors and costs of contraceptives after some experience with the program.

Activity 5

Population awareness is used here as a shorthand referring to the need for analysis and interpretation of population problems in their country to Afghan officials. This will be a continuing activity for which the USAID Director and the Population Division will be both managers and technicians.

The results of the national demographic sample survey and the projections which can be made from that data will give the RGA and international donor agencies a basis for planning for the first time.

The utilization of that data, its interpretation into economic and social implications will be of early concern.

The importance of this activity is in inverse proportion to the dollar requirements. This is an activity of making information available, of exposition and persuasion.

The USAID will undertake a continuing stance of being supportive to population awareness activities as opportunities arise.