EVALUATION REPORT
ON
EMERGENCY MEDICAL PROGRAMS
IN KABUL AND LOGAR PROVINCES, AFGHANISTAN
BY KINDERBERG INTERNATIONAL, e.V.

FOR
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I. EXECUTIVE SUMMARY

The purpose of my visit was to 1) evaluate all the existing programs of KBI, 2) seek the possibility of new projects, and 3) meet with key local officials and NGO partners.

1. Methodology of Evaluation

- Interviews to local staff members, beneficiaries, patients, village chiefs
- Review of statistics from HMIS, registration data
- Review of logbook
- Group discussions, such as problem tree analysis
- Observation
- Field trip

2. Key Findings

- **Projects will evolve into comprehensive, sustainable ones from curative, clinical focus.**

  Problems observed in our current programs are addressed in the following sections.

- **Capacity building for our local staffs to manage the program is urgently needed.**

  Areas of great need are such as supervision, close guidance, professionalism, and communication skills

- **Recruitment of expatriate personnel to deliver coherent message to local staff and provide close supervision is strongly needed.**

  Areas of concerns are skills in supervision, evaluation, and communication to the local staffs as well as among expatriate personnel

- **Emerging marginalized poor population at the periphery of Kabul is expanding rapidly.**

II.

BACKGROUND

MOH launched the nation wide campaign to implement BPHS with support from substantial donors, e.g. USAID, EU in the last two years. They select one lead NGO per province to implement this package. Musayi district, Kabul province is covered by USAID/REACH grant and local NGO, STEP was selected, while Logar province was covered by the EU grant and they selected MRCA as a lead NGO. Subsequently, our seven primary care clinics operating under AA grant have to be closed at the end of February so that these NGOs can take over clinical service as part of their BPHS.

Currently, KBI-Afghanistan has been operating several programs, 1) primary care clinics in Musayi and Mohammed Agar, Logar in eight locations. 2) Mobile team to cover Mohammed Agar district, 3) Winterization distribution, and 4) other programs described below. All of these programs are covered by the AA grant, which runs 6 months at a time, and stipulates that 50% of the requested budget should be used for "give away".

III. EVALUATION OF CURRENT PROJECT

Currently, KBI is operating 9 programs. The following is the outline of each program.

1. Eight existing clinics (BHC) in Logar and Musayi

1) Clinic

There are seven clinics in Logar province, six in Mohammad Agar district, one in Pli Alum, and a clinic in Alokhel. The Logar team consists of one MD doctor, one assistant doctor, one midwife, one pharmacist and one guard. The Musayi team has two MD doctors, one lab technician, one CHW, and one midwife.

Since last May, we are seeing approximately 20,000 patients per month in these eight clinics. This large volume is equivalent to any of the major tertiary care hospitals in Kabul. Age and sex breakdown of these patients are not regularly tabulated. It is not clear whether we see more adults than children.

On average, approximately 100 patients are seen daily in these 8 locations. Common conditions seen are ARI, diarrhea, back pain, HTN and UTI. This high volume of patients is seen by two doctors in a half-day period. The high volume with limited manpower raises questions about quality of care. In these clinics, medication is the main mode of therapy and people are coming in for medication rather than consultation. Subsequently, the variety of medications used in our clinic already surpassing the level of the "WHO Essential Drug List". For example, they use a proton-pump inhibitor, Omeprazol for gastritis rather than using cheaper Histamine H2 blockers. Some of the younger

physicians try to treat H.Pylori empirically with combination of expensive drug regiments even though there is no culture or blood work available to verify those pathogens.

Troubling trends of antibiotic usage were observed. Previous review two years ago revealed that a majority of patients regardless of their reasons for visit were prescribed some kind of antibiotic and this trend still continues during the current observation period. The length of treatment with antibiotics in individual conditions depends on the provider and there is no standardization of length of treatment. Antibiotics of excessive spectrum and strength not found on the list of "WHO Essential Drugs" are being utilized with limited rational. For example, Ampiclox, a combination of Amoxicillin and Cloxacillin is used in Otis and other conditions with unclear rationale. Double coverage of antibiotics with similar spectrum is common, for instance, Amoxicillin plus Bactrum for otitis.

HMIS data is tallied every month by physicians at each clinic. However, these sheets are significantly inconsistent with the registration data regarding the total numbers of patient per clinic per month. HMIS data sheet contains only major clinical diagnostic categories, e.g. ARI, diarrhea. Therefore, it would be useful only for surveillance for major infectious disease, e.g. measles or hepatitis. However, I do not know the value of further use of this system in primary care setting without any definite diagnostic capabilities of any diseases. Our medical staff does not seem to use these monthly statistics to discuss appropriateness of treatment or possible public health implications. Staff doesn't crosscheck the validity of data by simply comparing the databases; the monthly tally and HMIS data sheet. Unfortunately, it is obvious that our medical staffs do not fully utilize the concept of epidemiology with record keeping.

The majority of the children seen in the practice are not seriously sick. Most of them are suffering from common primary care outpatient morbidity, e.g. ARI, diarrhea, and skin conditions. Even though many patients are repeatedly seen in our clinic over the past few years, growth monitoring is neglected e.g. growth chart or growth curve. I had reviewed the use and importance of charting child physical development with these physicians on my previous visit two years ago.

Problems:

- Overmedication of the population.
- Medication as treatment rather than consultation.
- Collected data is not properly analyzed to improve our performance.

Suggested solutions:

- Implement standardized guidelines in all clinics regarding medication use.

- Limit number of patients seen by doctors through improving the capabilities of triage nurse.

- Introduce concept of growth monitoring by using appropriate standards (charts and graphs) for children.

- Train our physicians and midwives with basic epidemiological skills.

2) Lab

At the Musayi clinic, there are simple lab conducting U/A, Ht/Hb, stool culture, stool parasite and pregnancy test. The technician told me on average he examines 10 specimens per day for blood and stools. It is not obvious how the results of these tests change the management of conditions. The indication for these tests is not clear. There is a need for clear guidelines for laboratory work so that results can be incorporated into treatment.

Problems:

- Indication of each test is not clear. And how the result of the test would change treatment plans are not clear either.

- The result of the test is not utilized to tailor the treatment for entire family. For instance, positive Giardia should alert physicians for overall hygiene for entire family of the patient.

Suggested solutions:

- Strict guidelines for indications for each test and train physicians to follow these guidelines.

- Keep the investment for lab minimum: such as urinalysis and microscopic exam of urine and stool.

2. Mobile team

The mobile team provides home visits to patients referred from seven clinics in Logar province. The team visits each clinic on weekly basis. The team consists of one midwife and one CHW, usually sees 15 patients per visit. In the review of records from the past two months, 75% of patients seen in by the mobile team are women, mostly over 30 years

old, and the majority of them live between 5-10 Km from the clinic. Approximately 56% of them are disabled due to landmine injuries or other reasons. About ten cases per month are referred either directly (taken by the team to the hospital) or indirectly (the family of the patient arranges the transportation and go by themselves with our referral form) to hospitals in Kabul. More than half of them cannot comply those recommendations due to various reasons. Some of these reasons are 1) no transportation, 2) no accommodation for family members who accompany patients in Kabul, 3) they feel they don't get appropriate treatment even they go there.

Problems:

- Patient selection and priority is not clear.
- Follow-up of referral patients are not complete.

Suggested solutions:

- The reasons of visit, not the diagnosis (since the team doesn't have doctors) but chief problems or complaints, should be documented.
- More thorough follow up for referral cases is needed to find out the problems and solutions of current referral systems and the treatment in the referral facilities.

3. Winterization distribution

At each clinic site, KBI screens candidates for distribution project based on their socioeconomic parameters. Any household that satisfies more than or equal to five criteria is eligible for resources. Each qualified family will receive 40 kg of flour, 8 kg of cooking oil, 10 kg of rice, 2 kg of sugar, 2 kg of beans, and 2 packs of washing powder.

The criteria for eligibility is 1) orphan, 2) widows and female headed household, 3) refugee/returnee, 4) woman aged >60 years, 5) disabled, 6) malnutrition, 7) chronic disease, 8) TB patient, 9) high risk newborn, 10) women with risk pregnancy, 11) women in prison, 12) other, e.g. extreme poverty. I found that this "Other category", particularly extreme poverty is commonly sited for eligibility, however, the actual criteria of 'poverty' was not defined by the team. I observed distribution activities on two different occasions, but I did not observe any children or adults with obvious malnutrition. Villagers come to the site on the distribution day and collect their items. No further follow up or monitoring regarding the fate of these distributed goods was conducted.

Problems:

- Selection criteria for beneficiaries are not clear.

- Monitoring after the distribution is not conducted.

Suggested solution:

- Stringent inclusion and exclusion criteria should be developed and implemented.
- Monitoring should be provided for sample of beneficiaries for follow-up.

4. CHW training

KBI trained 16 male and 13 female CHWs in Musayi. I attended their final oral examination and graduation ceremony. Most of the female CHWs have been working as TBAs before they were trained as CHWs. Most of them delivered at least 5 babies since our training, which ended 3 months ago. The final examination was conducted as a one-on-one oral examination. As far as I could observe, most of these students were vocal and gave answers instantaneously when asked questions. Two of the male participants were Mullah of their villages.

Problems:

- Documentation of training log is not documented in detail and hard to follow what exactly students were instructed.
- There were more didactic lectures and less cases and scenarios.
- Students were tested in one-way and they didn't have a chance to evaluate their trainer. They didn't have a chance to discuss what is the purpose of examination and evaluation.

Suggested solutions:

- Develop curriculum to allow the group of students learn from each other and learn together.
- Let them take an ownership of the training so that they can use examination and evaluation for self-improvement.
- Make more case scenarios so that they can focus on practical knowledge and hands-on skills.

5. Follow up of TBA

Currently 178 TBAs (Sourh Ab 34, Ludin 36, Safed Sang 37, Dashtak 33, Alokhel 38) are actively working at their villages. They are in regular contact with our supervisor midwife and she provides supervision at one of our existing clinics. Their activities are followed up every three months and tally in several different areas of activities. Our supervisor midwife has been the key person to conduct this program. Outcomes in regards to referred cases and mortality cases were unclear and were not followed closely. Every three months, our supervisor midwife will go to visit those TBAs to refill their TBA kit and they obtain statistics from them and discuss their performance at our clinics. They use innovative illustrated tally sheet to record their activities. These data should be tallied and reported regularly. Besides, follow up of referral cases and mortality cases should be encouraged to assist to improve their performance.

Problems:

- The activities of TBAs are not well documented. We had no clue what they do and where they work until we saw the tally sheet.
- Tabulation and analysis of these tally sheets is few months behind.
- Follow-up of mortality and referral cases is not routinely conducted.

Solutions:

- Tally sheet should be collected on regular basis and should be tabulated for analysis on every three months.
- Follow-up and documentation of individual case of mortality and referral case should be implemented.

6. Jail program

Female prison is visited on regular basis once a week. The census of these female inmates is low. KBI also provided transportation for children visiting mothers to prisons. The total number of inmates visited so far is not clear.

Comments:

I didn't observe this program personally; there is no routine documentation for the

number of beneficiaries, time, and contents of visits. This documentation should be implemented.

7. Eyeglass project

A local NGO, NOOR comes to our Musayi clinic once a week to provide eye exam for villagers. On average, they screen 20 patients per week and give prescription for eyeglasses.

8. Leishmaniasis by HealthNet International (HNI)

HNI comes to our Musayi clinic to provide treatment for Leishmaniasis on a weekly basis in the past two years. They treat approximately 20 patients weekly by topical injection.

Comments for above two programs:

I didn't have a chance to observe personally either of these programs this time.

9. "Midwife Container"

With the previous AA grant, two 20-feet containers were refurbished to use as 'midwife container' to assist the teaching of midwife and their TBA students. Where and how these containers should be used require further discussion.

Problems:

- The program itself was designed without any feasibility studies in the field.
- The use of container is unclear as well as the suitable location of the container.

Suggested solutions:

- The location and the use of the container can be discussed with villagers. And we can negotiate with them to let them maintain by themselves.

IV. NEW PROJECTS

1. Mobile Team

Mobile team will be continued for another 6 months to one year as a ‘bridging solution’ to scale down our clinical service to a more comprehensive community based program. The reasons of providing mobile teams will be several fold: 1) As a phasing scale-down measure to move towards comprehensive approach to improve health of the population instead of providing clinical services, 2) Ensure the health care coverage in areas where we close our clinics and no new coverage under new NGOs, e.g. Dashtak, Abparon and Sourb Ab, and 3) Reinforce ‘on-site monitoring’ for the quality of care provided by new NGOs, MRCA.

The purpose of the mobile teams is not to duplicate BPHS service by sending medical staffs to houses at village level. Rather, it should work complimentary to BPHS by gaining trusts from people to BPHS through referring patients to clinics and hospitals. And we will also help establish a sound referral system through providing ‘halfway house’ for patients and their families referred from villages to care in Kabul hospitals.

The ‘halfway house’ would be a new addition to the mobile team project. By providing affordable accommodations for patients and their families during their stay in Kabul and in case for premature discharge from the hospital, we can ensure the patient recovery and facilitate communication between tertiary care centers and the primary care physicians at the village level. We do not intend to provide medical care; rather this is another complimentary strategy to enhance the referral from the primary level to the tertiary care levels by bridging major obstacles.

2. Alokhel, “women house”

This facility can be used for any formal and informal activities to connect women in the community. It can be a base for formal education or training, and informal base for information exchange, peer couching or peer education of any kind.

The facility has a lot of potential to accommodate many different activities, art, performance, weaving, gardening, training etc., not only for women, but also for children and families.

3. Sanitary goods distribution for ‘returned refugees’ in Kabul

Two thousand families are targeted for our emergency distribution program for sanitation goods. Based on our brief site visits, there is potential for sanitation crisis: open sewage, lack of water, filthy clothes, and untidy children running around open sewage and garbage dump were observed. The public health crisis is imminent if there is no intervention at this moment.

V. POTENTIAL OTHER PROJECT

1. Further duplication of "Women House" in Dashtak, Abparon

Expansion of the Women's House will be left up to the outcome of further discussion with villagers in our monthly brainstorming meeting in these villages. It is possible that KBI will help them to duplicate above-mentioned "women house" in these communities.

2. Nursery

This is one of the concerns came up in our "Current problems" workshop. Several female workers in KBI raised the concern for lack of sufficient childcare facilities while they are at work. Currently, there are not enough nurseries in Kabul. Considering the fact that more women will go out to work, particularly in Kabul city, the shortage of nursery is inevitable.

3. Mental health care for returned refugee

Even though there are publicities on this issue, not that many programs are providing mental health care. Using a public health approach, we can provide group activities or group play at our 'female house' or other modalities to address mental health issues.

4. Peace-education, conflict resolution for the youth

These are some of the topics that came out in our office brainstorming workshop and also this is one of the current programs of KBI in Balkans.

5. First aid training for taxi drivers

Taxi is the only modality to transport patients from villages to Kabul in emergencies. Taxi drivers saw numerous mortality cases during their risky transportation. We can provide very basic skills, such as patient transport to taxi drivers in villages.

VI. MEETING WITH OTHER NGOS AND THE MINISTRY

1. STEP

STEP is the winner of USAID/REACH grant for Musayi district, Kabul province and will be in charge of implementing BPHS in this district. They already started to refurbish a house to open a clinic as BHC with a doctor 2 km away from our current location in Alokhel, Musayi. They also took over an old SCA clinic as one other location for BHC. They are interested in opening an EPI center in Alokhel village by hiring vaccinators and

put together a cold chain. They also have hired staff from the Charya Sap district hospital.

2. MRCA

They are now in charge of implementing BPHS in Logar province. They will not provide BHC service at three of our current locations, Dashtak, Abparon or Sourb Ab. MRCA is also asking their health staffs recruited from Kabul to live in Logar province. In stead, they are offering these staffs some attractive benefits, e.g. let them use hospital equipment after 4:00pm for their private practice.

3. MoPH

The ministry of health is now in transition under the new administration. They changed their name to ministry of public health. The implementation of BPHS is the first priority for the ministry. The new minister, Dr. Fatimi believes that any NGOs could be beneficial as long as they will not compete with lead agencies implementing BPHS. This approach is not well appreciated throughout the ministry yet, some of the members of the ministry believe that all extra funding other than BPHS should be directed to implement the package for other provinces since 23% of the nations is still uncovered by any NGOs.

Soon after Dr. Fatimi took office in MoPH, he commented publicly that some of the NGOs are performing poorly. He implied that there is a possibility of revocation of contract with NGOs depending on their performance. In reality, there is little monitoring or evaluation in the MoPH at this moment. Therefore, it will take for a while that NGO execute project on contact-basis rather than grant-basis.

VII. FUTURE DIRECTION OF AFGHIAN PROJECT

This is a period of major change for KBI programs in Afghanistan. We are forced to scale down our operation closing our clinical services. We decided to look into a comprehensive approach to health rather than clinical services and eliminating drug distribution. We subsequently will focus on two areas, women house and continuation of the mobile team. As long as we will implement the AA project, the same principles will apply, more than 50% give away and a 6 months project cycle.

As we move into comprehensive aspects of health issues in villages, the input from villagers becomes critical. We successfully maintain our support and trust with villages where we've been operating our clinics in the past two years and we keep our dialogue and our presence in these villages. The further goal of this comprehensive approach is to make these programs locally sustainable eventually, let people help each other to manage, maintain these programs. Therefore, the recruitment and training of the local personnel

will be the key for the success of our projects.

By eliminating clinical services, we can also eliminate the need of expatriates with specific medical knowledge, e.g. physicians or nurses. We really do need an expatriate who can provide supervision and guidance for project management, monitoring, and evaluation.

Another significant finding is that rural is not equal to poverty. Marginalized urban population seems to have much higher health risk than rural poor. Unfortunately, these urban populations are rapidly exploding in size.

VIII. ORGANIZATIONAL ISSUES

Organizational and administrative issues should be addressed in order to ensure effective and timely execution of our projects. Many of these issues require urgent and serious attention for improvement. I would like to divide these problems for local staff and HQ/ expatriates issues.

1. LOCAL OFFICE AND LOCAL STAFFS

1) Lack of professionalism

Unprofessional behavior is rampant and should be corrected. It will affect our sense of ethics, efficiency and eventually accountability of our program. These problems and suggested action plans are as follows:

a) Poor planning skills

It seems so painful for local people to prepare anything ahead of time. There is no long and medium term schedule, e.g. weekly or monthly, posted on the board for everybody to share.

Drivers for our vehicles didn't fill up tanks each day after their trip. Often, we had to stop by to tank up diesel for our vehicle, buy some chains for snowy road, etc, and we were consistently behind our schedule for our meetings or our clinics.

Despite the fact we announced the graduation/final exam day for our CHW, our staffs failed to announce the close of our clinic that day. We subsequently ended up scrambling to see patients while conducting graduation ceremony.

Even though they had enough time to prepare the certificates for CHW, employees failed

to print out these documents on time to get signatures from MoH. In the end, CHWs were given certificate without MoH signature.

They don't plan their holidays or vacations ahead of time. They usually ask for a day off one day ahead of time.

Suggested action plan:

- Go over schedule repeatedly weekly and monthly ahead of time.
- Compare their schedule notes every day and make sure everything is followed up properly and nothing is left to follow up.
- Unless they claim their vacation or office holiday (except emergencies) one month ahead, they cannot take that day off.

b) Lack of punctuality

During my stay for four weeks in Kabul, employees were always late. I never saw full attendance by employees by 8:00am. However, they never failed to go home by 3:30pm. I rarely saw anybody stay beyond 4:00pm in the office to finish his or her work.

Suggested action plan:

- Introduce timecard to keep track of their work hours individually so that they get paid based on hours rather than days per month.
- Provide them an easy format to use such as current RTS form so that they can easily communicate with HQ on regular basis.

c) Anxiety for future as professionals

Many of our technical staff, doctors and midwives feel that they have limited opportunities to continue to grow in their area of expertise. They don't have easy access for resources such as textbooks or CD-ROM, but at the same time, they cannot read foreign textbooks or CDs freely. I believe it's important to provide them continuing medical education (CME) as much as we can to provide them appropriate knowledge and skills. This will help them to gain self-confidence to what they are doing.

Suggested solution:

- Recruit experts who can conduct CME seminars, lectures besides seeing patients.
- I am not keen to send them English textbooks because most likely these will be ended up in their private clinics.

2) No effective communication

a) Poor documentation skills

Documentation skills of our staff particularly in English are fairly limited. They don't use computer programs, e.g. Word or Excel effectively to communicate with other people. They don't routinely use Excel to tabulate statistics they tallied or make charts or graphs.

It usually takes a significant amount of time for our local staffs to perform tasks require written documentation. Consequently, our local staffs failed to communicate with HQ in timely manner in the past.

Suggested solution:

- Let them write more and let them write with deadline so that they can perceive what and how much they can do and cannot do. This concrete experience will provide them good baseline for learning writing skills.

b) Less information sharing

They see each other almost everyday, but they don't communicate effectively regarding the project or their tasks. They don't share their problems or updates with other colleagues. Again the example would be that graduation day ceremony for CHW: one doctor thought that the medical director would cancel the clinic while the medical director thought that would be the responsibility of CHW supervisor.

Suggested solution:

- Regular office meeting with our staffs to share their difficulties and problems as well as their timely updates. They are welcomed to share their project-in-progress. Sharing information and transparency among staffs are important aspects of teamwork to enhance the performance as a team.

3) Lack of supervision

a) Lack of supervision from expatriates

Expats and HQ failed to provide appropriate technical supervision needed to execute high quality program. For instance, monthly medical report (MMR) does not make any sense at all as a tool to improve our performance. Local staffs didn't have any workshop or discussions why they tally, tabulate and how to analyze these data. Without the training, they cannot conduct meaningful analysis on our morbidity data from our clinics.

Suggested solution:

- Expatriate should provide rigorous workshop for administrative topics as well as specific technical issues, e.g. continuing medical education (CME) etc.
- We should recruit expatriate who is willing to provide these workshops and technical supervision rather than simply seeing patients by themselves.

b) Lack of supervision from local supervisors

Our supervisors, e.g. medical supervisor, supervisor team, fail to provide meaningful feedback or constructive criticism to their colleagues. Our medical supervisor, for instance, doesn't provide monthly summary for our doctors what they're doing, how we can improve our service, what we should have done according to the monthly statistics he reviews.

Suggested solution:

- Close supervision and on-job training by our expatriates for local supervisors for their leadership role.
- Send them to mini-workshop on management and supervision by other NGOs in Kabul.

2. HEADQUARTER(HQ) AND EXPATRIATES

1) Centralized command structure

Many decisions regarding our projects are made in headquarter rather than in the field office. The organization has vertical command structure rather than horizontal. This structure is highly effective in making decisions and implement programs in short period of time. However, this type of management style has several shortcoming as well: 1) field personnel tends to feel exclusion rather than inclusion since they feel their voice is not heard well, 2) field personnel has difficulty to have a sense of ownership for the project. Therefore, it is difficult to nurture local sustainability of the program, and 3) certainly this style is against the concept of decentralization and self-reliance of local staffs and local project.

There was a concern among local staffs that their voice doesn't have much weight for making a project or program. This feeling among our local staffs would be counterproductive for our program in the long run since we are aiming at making our

program locally sustainable eventually.

Suggested solution:

- In order to increase the transparency of the program and organization, regular meetings at local level and HQ to let everybody get involved, informed and let them feel that their voice is heard.
- Include our local staffs in our decision making process. At the same time, assign them a task with responsibility to let them understand the responsibility and decision-making comes together. (They cannot be irresponsible once they make some decisions.)

2) Lack of supervision by local supervisors and expatriate personnel

During our workshop in professionalism and communication issues, it became clear that local staffs feel that they don't have sufficient feedback from their superior. It is critical for expats personnel to provide constructive feedback and timely feedback for performance of these local partners.

3) Inconsistency of supervision among expatriates

There are inconsistency among expatriates regarding management style, strategies, and opinions towards our program. Due to the poor overlap between our expats and non-existent sign in/sign out documents, it is extremely difficult to provide coherent messages to our local staffs.

Suggested solution:

- Mandatory overlap of stay among expatriates up to a week.
- Mandatory written report from expats who finished their assignment within 2 weeks, preferably in English, but if they can't, even in German.

4) No evaluation of the program

In most of our program, evaluation of the project is not included. However, this is a serious flaw as an organization. Lack of evaluation means lack of learning from what we've done. I believe evaluation would significantly help us improve our capacity as an organization.

Suggested solution:

- Routine evaluation at the end of the project should be conducted and the results should be discussed and disseminated.
- Send our HQ staffs and expats for workshops and seminars for NGO personnel often conducted in Europe, e.g. UK, Belgium.

IX. WORKSHOPS & LECTURES

1) Office workshop

The first workshop using the Problem Tree Analysis was conducted on 1/21 in our office. I asked them to write five concerns they had regarding their work. There were numerous concerns including, low salary, no nursery for their children during their work, anxiety for future of Afghanistan, communication gap inside the organization, and lack of opportunities for professional growth. They voted for 'low salary' for their most significant concern and we decided to discuss the topic.

I took this opportunity to let our local staffs exercise the Problem Tree Analysis. After two hours, they came to realize that the main problem was related to KBI's funding structure. Since we took their most serious concern as the topic, we had a good engaging discussions to exercise this analysis among them.

2) Retreat & Workshop

We took our office staffs and project teams to "Lucky Town Restaurant" close to our office on 2/5 and conducted a half-day workshop and retreat. The purpose of the workshop was to discuss our two most concerning problems in the office, the professionalism and the communication skills. I also intended to listen to their perception of the problem. In both discussions, I realized that they don't recognize the problems internally, just tried to blame others. I also noticed through this workshop, their 'victimization' mentality is still pervasive. They attribute any of their shortcomings to the long-standing war. While they perceive themselves as poor victims of war and chaos, they are refusing or cannot get on to this new era of rapid change in their society.
I came to realize there are several things important working with our local staffs. My recommendation would be:

- Timely, individualized feedback and constructive criticism at each time there is a problem.
- Constant reminder and close supervision for details.
- Recognition and rewards for their good performance so that we can enhance their self-confidence.

3) Village workshop on poor health in Dashtak and Alokhel

We conducted two workshops using the Problem Tree Analysis to discuss their poor

health with village chiefs in Dashtak and Alokhel. I started with the explanation why we had to close our clinics and explained our intentions to work with them in other forms to assist their health. Then we opened our discussions for their perception for poor health. In both occasions, there are many problems emerged, such as lack of water, hygiene, education, jobs, and access to health care for pregnant female. It turned out that mobile team can fill in many of their perceived problems for health care needs. Regarding other issues such as education or water supply, I stressed the importance of collaboration with other organizations or government agencies since KBI cannot provide solutions to all the problems. We all agreed to maintain our dialogue on regular basis.

4) Ludin CME seminar

Twenty physicians in Mohammad Agar district in Logar province attended the continuing medical education seminar (CME) sponsored by Kinderberg International and Case Western Reserve University. This is the first CME conference in Afghanistan. Despite the fact the lecture was given in English and translated into Pashto, there were active discussions throughout the meeting. Many participants asked us to provide similar opportunities on regular basis.

5) Other lectures

I provided several lectures for our office and project staffs. The topics included basic epidemiology, Congestive heart failure, hypertension, community assessment, and how to facilitate ‘problem tree analysis’.

X.

APPENDIX

Appendix A. Pharmacy inspection (January 21, 2005)

Compared to two years ago at my first visit, the inventory of drugs has been significantly reduced. They eliminated all of the Cephalosporin antibiotics. As for antibiotics, they have still been using quite a few kinds of medications including Amoxicillin, Bactrim, Chloramphenicol, Gentamicin, Ciprofloxacin, as well as a combination medicine called Ampiclox. This is a combination of Ampicillin plus Cloxacillin. They use several different kinds of an antifungal medication. However, they use quite a few vaginal suppositories without any gynecological examination. The interesting observation for this inventory review was that they have still been using a Nifedipine as an antianginal medicine, which was manufactured in Iran. They also use a Tylenol # 3 (acetaminophen with codeine) syrup for pain control as well as using a Digoxin and Hydralazine for blood pressure control and for congestive heart failure. There are several anti-seizure medicines including Phenobarbital and Haloperidol. There are a couple stomach medicines, which include Omeprazole, a proton-pump inhibitor. This medication is not on the WHO Essential Drug List. I did not see any inhalers, inhaling solutions or MDI (metered dose inhaler) for asthma or breathing problems. Even though the inventory of the medication has been reduced, the indication of many of these medications is not clear.

Approximately 50 % of the medications are expectorants, which can treat the symptoms, not necessarily the cause of the disease. The injections available include Penicillin as well as the Lidocaines for minor sutures. The large number of medications is expectorant for symptomatic treatment; therefore, the true necessity of treatment by giving away these medication is unclear. There are serious concerns regarding the usage of cardiac medications including Digoxin**,** Beta-blockers as well as Calcium Channel Blockers. At the same time, the treatment dose for simple cardiac diseases such as hypertension is unclear. I did not see any medications like hydrochlorothiazide (HCTZ). Over all, there are several serious concerns about the usage of the medications.

1. Appropriate indication of the medication for certain conditions.
2. The dosage and the length of use of the medications.
3. The overuse of expectorants as well as pain medications, including codeine.

Appendix B. Office Retreat & Workshop schedule

Kinderberg International, e.V.
Retreat & Workshop

February 5, 2005

Kabul, Afghanistan

Schedule

8:30am – 8:45am	Orientation and Objectives
8:45am – 9:15am	Long-term goals
9:15am – 10:30am	Professionalism workshop
10:30am – 10:45am	Break
10:45am – 12:15pm	Communication workshop
12:15pm – 12:45p	Lunch
12:45pm – 1:15p	Where are we going from here?
1:15pm – 1:30pm	Questions and comments
1:30pm	Adjournment

Appendix C. CME seminar syllabus

Clinical Updates
on
Common Problems in Primary Care

February 9, 2005

Ludin Clinic
Logar province, Afghanistan

Sponsored by:
Kinderberg International, e.V.
Flower St. #4, Kabul, Afghanistan

Case Western Reserve University
Cleveland, OH USA

Dates & Location:

February 9, 2005 (Wednesday)
Ludin Clinic, Logar province
Afghanistan

Faculty:

Dr. Tahir Furmoly, MD — Medical director
Kinderberg International, e.V., Afghanistan

Dr. Mori Morikawa, MD, MPH — Vice President, Kinderberg International, e.V.
Stuttgart, Germany

Assistant Professor
Departments of Family Medicine, Global Health and Diseases, and Epidemiology & Biostatistics
School of Medicine
Case Western Reserve University
Cleveland, OH USA

Schedule:

10:00 am – 10:15am Welcome and orientation

Dr. Furmoly, MD

10:15am – 10: 45am Update on our practice in Logar

Dr. Furmoly, MD

10:45am – 11:15am Primary care in the district, what are we seeing?

Dr. Morikawa, MD, MPH

11:15am – 11:45am	Hypertension updates
	Dr. Morikawa, MD, MPH
11:45am – 12:15pm	Congestive heart failure in 2005
	Dr. Morikawa, MD, MPH
12:15pm – 12:45pm	Questions and answers
	Drs. Furmoly & Morikawa
12:45pm – 1:00pm	Plan ahead: CME, M&M conference
	Dr. Furmoly
1:00pm	Adjournment

Primary care in the district, what are we seeing?

Mori Morikawa, MD, MPH
Assistant Professor
Depts of Family Medicine, Global Health & Diseases,
and Epidemiology & Biostatistics,
School of Medicine
Case Western Reserve University
Cleveland, OH
USA

After this session, participants should be able to

1. Define the characteristics of primary care practice compared to tertially care.
2. Understand the difference between disease and illness
3. Understand the importance of community intervention

Hypertension updates

Mori Morikawa, MD, MPH
Assistant Professor
Depts of Family Medicine, Global Health & Diseases,
and Epidemiology & Biostatistics,
School of Medicine
Case Western Reserve University
Cleveland, OH
USA

Objective:

After this session, participants should be able to

1. Understand the stepwise strategy to control HTN.
2. Formulate diagnosis plans to workup for secondary HTN.

Summary:

Hypertension is a common condition worldwide. Unfortunately, the incidence and prevalence are increasing in many parts of the world. The understanding of proper management strategy is essential for primary care providers.

Joint National Commission report No. 7, (JNC 7) came out in 2003. This new guideline has some changes since the last edition incorporating some of the new clinical trials such as ALLHAT trial.

Even though majority of hypertension is still essential hypertension, it is often important to know the proper workup strategies for secondary hypertension.

Outline:

1. Natural history of our blood pressure

   Framingham Study

   J-phenomenon

   New definition and JNC 7

2. Argument continues: systolic vs. diastolic, which one counts?

   Isolated systolic hypertension

3. Strategies for selecting anti-hypertensive medications considering comorbidity (compelling indications).

4. Strategies for workup secondary hypertension

   A
   B
   C
   D
   E

Bibliography:

Onusko E. Diagnosing secondary hypertension. *American Family Physician* 2003;67:67-74

Franco V, Oparil S, Carretero OA. Hypertensive therapy: Part I. *Circulation* 2004;109:2953-2958

Franco V, Oparil S, Carretero OA. Hypertensive therapy: Part II. *Circulation* 2004;109:3081-3088

Congestive heart failure in 2005

Mori Morikawa, MD, MPH
Assistant Professor
Depts of Family Medicine, Global Health & Diseases,
and Epidemiology & Biostatistics,
School of Medicine
Case Western Reserve University
Cleveland, OH
USA

Objectives:

After this session, participants should be able to

1. Understand the new classification of CHF
2. Address strategies to treat acutely decompensating CHF

Summary:

Congestive heart failure is still a devastating condition. CHF is a condition and final common pathway of different etiological entities. Even though many trials still focus on systolic dysfunction, the incidence of diastolic dysfunction is rapidly increasing. In the past three decades, despite all of the clinical trials, overall survival rate for all class NYHA class combined showed no significant improvement.

On the one hand, new treatment modalities including cardiac resynchronization therapy (CRT) or LV assisted devise are now available; the importance of prevention and early detection in high-risk group is imminent.

Outline:

Evolvement of concept of pathophysiology:

"Pump failure" model

"Sympathetic hyperstimulation theory"

"RAAS" activation

"Peptide cascade" vs. "RAAS" as compensation of CHF

Clinical classification at the bedside

NYHA classification

I
II
III
IV

ACC/AHA new classification

A
B
C
D

Treatment modalities for systolic dysfunction

Assessment of acutely decompensated CHF

Bibliography:

Jessup M, Brozena, S. Heart failure. *New Engl J Med* 2003;348:2007-18

Nohria A, Lewis E, Stevenson LW. Medical management of advanced heart failure. *JAMA* 2002;287:628-640

Appendix D. The analysis of “Mobile Team” data

1) Age distribution

2) Distance from the clinic

1) Disabled patients

Appendix E. The analysis of clinics from May 04-December 04

Appendix F. Official name of the villages

Official Kinderberg Village Names to be used for AA Projects

1. Alokhel	AL
2. Safed Sang	SS
3. Ludin	LU
4. Dashtak	DA
5. Sourkh Ab	SA
6. Abparan	AB
7. Deh-e Naw	DN
8. Altamur	AM

Appendix G. UNICEF meeting (January 22, 2005)

With Dr. Chris Hirabayashi, MD, PhD

Dr. Hirabayashi has been in Afghanistan as the chief of Health and Nutrition for UNICEF in the past two years. As far as he knows the health sector in NGO in Afghanistan has not been increased since the Taliban regime was overturned. Approximately 15 NGO's including BRAC, IbnSina as well as IMC have currently been providing health care systems for the majority of the Afghans. Also, after the general election last October, the Minister of Health (MOH) is going through a transitional period to organize the formation of a new ministry called the Ministry of Public Health. Subsequently, at this moment the government structure has also been going through some transition and confusion. UNICEF conventionally has been providing the following health care related projects.

1. EPI
2. CEOC (Comprehensive Emergency Obstetric Care)
3. Iodine supplementation
4. Antianemia education

Other countrywide interventions include IMCI (Integrated Management of Childhood Illnesses), and supplementation of vitamin A and against other micronutrient deficiencies. UNICEF, however, does not generally support the training program; particularly they are not supporting the concept of the traditional birth attendant or TBA. The concept of TBA varies significantly nation-to-nation and region-to-region and at this moment it is not standardized. Therefore, it is not well targeted in terms of the beneficial target of intervention.

Comprehensive emergency obstetric care has been proposed approximately about 1 for 500,000 per populations and practically CEOC is supposed to provide one per each province. Here in Kabul, JICA has been helping to implement CEOC in one of the women's hospitals. However, C-section rate at the tertiary care referral institution is as low as 1%, which raised concerns about the validity and effectiveness of this intervention based on the hierarchical referral system and their capability of emergency surgical obstetric interventions.

Midwife education has been reformed and Auxiliary Midwife has been renamed as Community Midwifes and is trained in the hospital. They have to go through 18 months of schooling and practical training followed by on-job training. For instance, in Jalalabad, the Health Net International (HNI) has been providing a community midwife training. However, the recruitment has been going through numerous difficulties due to cultural as well as societal differences.

In the newly organized Administration of Public Health, three deputy ministers are currently working toward the integration of mother/child health care (MCH). The first person is Uzbek, an OB/GYN clinician, the second Dr. Kakar, is in charge of policy and prevention, and third is the deputy director for administration for the project.

At this moment, I got the impression that there is no magic bullet to decrease the maternal mortality rate (MMR) significantly, even though that is the national priority in health care in Afghanistan. It seems like UNICEF and other international agencies, which are advising the Minister of Public Health have been struggling through to implement or even find out the best intervention to tackle high MMR. Based on the conversation today, there is a problem list that has emerged.

1. Discuss with Minister of Public Health for the national guidelines to tackle to lower the MMR, which is currently one of the most significant health care issues in Afghanistan.
2. Discuss with local, as well as international NGO's, their approach for MMR issues and their strategies either education vs. surgical interventions.
3. Follow up of the near miss-cases as well as the difficult referred cases by our mobile team. The subsequent outcome of these cases will tell us more demographic as well as cultural characteristics of these near-miss cases. This will provide us some clues to community-based intervention for decreased MMR.

Appendix H. Review of Community Health Workers Team (CHW)
January 23, 2005

CHW training is an integral part of the basic health package implemented by the Management Science for Health as well as the Minister of Health in the past two years. Dr. Zahir has been in charge of organizing and conducting the CHW training for Kinderberg International. In Musayi Clinic, in the south of Kabul, the CHW training focuses on 16 male and 13 female CHWs. The students are based on the MSH guideline based on age between 20-50, recommendation by the village chief, and approval from the community. I reviewed the training logbook since January 8, 2004. The trainings are based on the didactics and the practicum, which typically runs for four hours (8:30 – 12:30pm). Main topics would include anemia, malnutrition, breast-feeding, diarrhea and ARI. From this training logbook, the details of health education they provided at home visit was not clear. The supervisors didn't document their interactions and results of their questions and answers with their trainees.

For example, interactions on November 28, 2004, they stated "at the beginning was asking past lessons about drugs (medications), everyone answering good".

November 29, 2004 - "today was the beginning of the third course practical program by two CHWs and we went to one village Halem and he checked same patient and injected patients". (It is not clearly documented what exactly they injected).

December 5, 2004 – "male CHWs worked in the Musayi Eye Clinic, today they injected same patients and checked the patients. Female CHWs worked in the Rhamatahad Clinic. They also injected same patients and checked the patients". It is vaguely documented what exactly they injected and why they injected the same patients. The indication and nature of the injection is rather unclear.

December 8, 2004 – They also mentioned during the course some common skin diseases, which include impetigo, scabies as well as other eye conditions.

December 29, 2004 – There is a description about the experience in dressing changes in leg ulcer patient. "The female and female CHW worked in the Alokhel Clinic today and they checked about 20 patients for ARI, diarrhea, malnutrition and other diseases. They also had one patient who has burn and trauma, they had dressing".

There are several concerns regarding the CHW training and it's hard to understand the contents and actual interaction based on the logbook. It seems that there is extensive coverage on the topics guided by the MSH as well as the WHO textbook and guidelines. However, the actual interactions as well as the integration of the knowledge and skills are not well documented. Actual patient provider interaction has not been documented neither has any of the psychosocial aspects been discussed during the course. In theory, there is a concern and possibility that we are missing the conceptual background of the

development of CHW in this community. One of the biggest concerns about this program is the entire training merely provides the technical aspects and knowledge base rather than the philosophy of CHW training which would lead to encourage and empower this community in the long term. Further discussion of this topic will leave until the actual interaction with the CHW trainees as well as the trainers.

Recommendations:

1. Early implementation of a team building, empowerment theory into the CHW training.
2. Considering the high rate of illiteracy, that leaves us to develop a more visual rather than numerical presentation of the materials.
3. We will encourage the CHWs supervisor team to document not only the facts but also their observations and their comments about the interaction between the trainees.

The topics described in the logbook are as follows:

Anemia
Malnutrition
Breast-feeding
Diarrhea
ARI
Malaria
TB
Scabies
Trauma
Burns
Impetigo

Appendix I. Meeting with Dr. Fatimi, MD, the Minister of Public Health
(February 1, 2005)

I had a chance to meet with Dr. Fatimie, the Health Minister of Afghanistan and the provincial health director of Logar, Dr. Naib-khil. I discussed primarily three things with the minister:

1. We need the contract retrospectively during the period of November 1 until the end of February, which we have covered under the funding from the ministry of foreign affairs of Germany to the seven clinics in Logar Province in Afghanistan.
2. I discussed our intention to stay and operate in Logar Provinces to cover our existing seven clinics and we will try to subcontract with MRCA, the French NGO who was selected as the leading agency for Logar Province for the implementation of basic health package. The minister enthusiastically agreed to support our existing program and he recommended that we negotiate with MRCA to subcontract and to cover our existing clinics during the grant period. He also feels that that the Basic Package Health System (BPHS) is missing several pieces that are not culturally sensitive. For instance, the mental health for children is totally not included even though people in Afghanistan have been suffering for 25 years of conflicts and war. He also believes that female Leishmaniasis should be covered, particularly for the female because of the disfiguring nature of this disease on the face. In Afghanistan, particularly for the female, the disfiguring of the face has significant stigma in their society.
3. He is concerned about emerging infections related to environmental issues particularly in Kabul because of the increasing amount of dust and environmental wastes. We both agreed that BPHS should be modified on a local and cultural context.
4. The final point that the minister and I discussed was our mobile team. In order to establish the BPHS system, there are three assumptions that we agreed on.
    a. Sound referral system
    b. Trust by the people for the BPHS system
    c. Higher tier will see the patients referred from the lower tiers.

Our mobile team has been seeing 15 – 20 patients in one location every week. We found that more than 50% of the patients we visited via mobile team are disabled. This is either due to landmine injuries or various other reasons. We constructed this team, consisting of a midwife and one CHW, as complementary support for the existing clinic rather than creating a new mobile clinic. This is the system to achieve the trust for this clinic as well as the health pyramids structure in Logar Province. I explained our intention to extend this program to cover the lodging for the family of the patients referred to the hospitals in Kabul. Among our referral cases, up to 50% of the patients do not go to the hospital even upon medical advice. One of the major reasons for their refusal to go is the lack of

lodging for the family members that accompany the patient. The family member has to pay more than 200 Afghanis to stay in overnight lodging in the capital, Kabul. Many poor villagers can't afford to pay that price simply because of economic reasons. By contrast, the medications at the hospital are about 5-10 Afghanis due to their coverage by the public hospital. Therefore, I propose the creation of providing lodging services for family members of patients that are referred by the mobile team to the capital city. The intention of this program is to again strengthen the referral system so that we can enhance the structure of the BPHS in the province as well as in the country. Again, this is not an ambulance service or mobile clinic. The purpose of the mobile team is to enhance the trust for the existing health pyramid system as well as strengthen the referral system to the capital city.

The health minister said that he was enthusiastically supportive of this program and he will ask us to apply for more German governmental funding for these purposes. He agrees to set up another meeting with Kinderberg International as well as MRCA with the Minister of Public Health acting as the mediator for the negotiations for the province of the Logar health care system.

Appendix J. Interview Survey for Female Patient at Malalai Hospital

Our midwife and office staffs conducted the following interviews using structured interview template. The sample was selected via convenience sampling. The interviews were conducted during the mid-day around noon. The following descriptions are from interviewers' note.

Patient number 1 (normal delivery)
The patient is from Kabul living in Callai-Fathullah.

She came in the morning due to heavy bleeding. After her checkup, she was released and at noon returned and delivered her baby. Her husband accompanied her. For the family members that accompany the patient in the hospital, there were separate waiting rooms for the females and males. However, there is no bed or couch for the family that stays overnight. Food has been provided for patients, 3 times daily. However, if the patient missed that distribution time then they will not save lunch or supper for the patient. The quality of the food is fair. In fact, at breakfast they served fruit, no bread but milk and one boiled egg and glass of sugar. Boiled water is also available for making tea. The patients stated that the medication is not sufficient enough and mostly the patient has to pay to buy. The majority of the patients are satisfied with the quality of the staff work. The rooms are warm and clean. Family members accompanying the patients cannot stay in the patient's room. In fact, family members are allowed to visit the patients within specified visiting hours, which is 12 noon to 1:00 pm and 5:00 pm to 6:00 pm. The number of visitors is not limited in most of the cases. If the patient is severely ill, her family members can stay inside the patient's room with the patient. There are no stringent guidelines for the lengths of hospital stay; it really depends on the patient's condition and recovery. It can sometimes be for a few days up to weeks or months. There is a cleaning woman on the floor and she does provide the help for the daily chores such as cleaning and other supporting activities as bringing food, making tea, etc.

Appendix K. Workshop in Dashtak
February 7, 2005

We conducted another workshop at the Dashtak Clinic in order to explore the possible collaboration with the villagers on a sustainable basis for the long term. We were supposed to meet with the chiefs from the eight surrounding villages of the clinic. However, due to miscommunication we ended up taking the available person in the clinic that day.

Approximately 20 male members of various age groups attended the meeting. First, I explained the current structure of the health care system in Afghanistan, in general. I tried to get them to understand the structure of the problems as well as the structure of implementation of this BPHS nationwide. I explained that Kinderberg couldn't provide any health care under this new regulation. Therefore, we cannot continue the clinical clinic beyond the end of February. Secondly, we had an open discussion using a problem tree analysis to see what is the contributing factor for their poor health. The first few minutes, most of the people were preoccupied with the fact that poor health is directly the consequences of a lack of access to the clinics. However, as we explored several different options, people started to speak up and a couple of good ideas emerged from the discussions.

> These included lack of water, lack of hygiene, lack of education, poor care for the pregnant woman, lack of transportation and difficulty with the transport of patients to Kabul.
>
> We also explored what the difficulty was in deferring patients to Kabul. The people stated that there were several reasons. For instance, one participant explained the fact without knowing any proper conduct, it is extremely difficult for them to select the proper facility, articulate the problem in their own terms, and even to convince the hospital guards to let them enter the hospital.
>
> Also, there is a problem of accommodation for the family members that accompany the patient.
>
> There is also an issue of the services at the hospital. There are serious concerns for the level of the services they obtain from the hospital.
>
> Regarding education, they stated that there are not enough textbooks for each student as well as a serious shortage of stationery goods for the pupils. The government promised the building of the schools but there is no established structure for the schools yet in the community.

For a safe order, they do not know the exact reasons, but probably due to the fact that

Afghanistan in general, particularly in the northern part, has been hit with a serious draught over the past five years. That is the contributing factor for the poor access to safe water. Some of the villagers have actually tried to dig a deeper well, approximately 50 meters, however they could not obtain any water.

One other issue related to poor health was poor nutrition due to the fact that they cannot utilize the farming land properly and more effectively due to the lack of enough water as well as the limited use of the land. One of the reasons for the limited use of the land is still the high number of unexploded ordnances as well as the antipersonnel landmines left in the mountains. One of the NGO's did come to clear the mines at one time, but only cleared along the main road and they didn't do a thorough investigation high in the mountains. We spent almost one and a half hours analyzing the tree to delve into the reasons of the contributing factors for the poor health and we realized that there are two different existing problems in the tree.

1. The difficulty utilizing the existing health care systems articulated and tailored in the BPHS system. This is still extreme difficulty to access the proper health care due to the lack of transportation or facilities.
2. Difficulty to utilize the referral system due to several reasons.
    a. Lack of knowledge as to how to utilize the health care facilities in the capital city.
    b. Bureaucratic structure of the hospital system curtailed the use of their systems by the people who are not familiar with the system.
    c. Expensive accommodations for the family members who accompany the patient to the hospital.
    d. Anxiety and mistrust among the villagers to trust the public sector health care system such as medications and exact services obtained there. For instance, one of the villagers articulated that they were discharged from the hospital at 10:00pm and they were literally at a loss as to what to do and they didn't have a place to stay. These negative experiences combined together acerbate their mistrust and low expectations to the existing health structures.

Four long-term program problems related to their poor health care related issues are:

1. poor access to safe water.
2 low level of education
3. shortage of nutritious food
4. lack of work and the local economy

In the end, I summarized the problems for the villagers to approach in two different tiers. One is short-term and other is long-term. As for the short-term program, Kinderberg International will continue to provide the mobile team to support the difficulty to access health care as well as their ease of referral to the existing clinics. Also, Kinderberg International mobile team will provide and support the referral service system by

providing a halfway house to support lodging for family members as well as the patient upon discharge from the hospital.

As for the long-term support for health issues in the villages, we agreed to continue regular meetings on a once a month basis to keep discussing these health related issues with the villagers. We also agreed that we need a multidisciplinary approach to solve the problems and also more involvement by the villagers.

Appendix L. Observations in three resettlements for returned refugees
February 8, 2005

There was a report in the past few weeks of the death of several dwellers inside the encampments scattered in the outskirts of Kabul due to the freezing cold weather. There is a well-known encampment for returned refugees and internally displaced persons in the last few years. The precise number and estimates are unknown. However, it seems as if there is a growing number of migrants that are building illegal dwellings inside the cities. We obtained a list of refugee camps and resettlements from the Ministry of Refugees and we decided to visit three of those encampments.

The first was the Karthe Parwan Camp and reported as having 44 family members living there. We walked through the camp to its center. There were two visible hand pumps. All the houses are adobe walled with plastic sheet roof supplied by UNHCR. I could see open sewage from drains out of these adobe houses as well as the open garbage dump. Obviously, there are no garbage collections. At a glance, all the children that I could see had no significant malnutrition. However, there is a significant shortage of hygiene materials and the hands and legs of the children are very dirty. There are no obvious skin diseases except in the second camp, which accommodates 15 family members, there was one boy with obvious pus discharge from the eyes. Conjunctivitis in general suggests the significant shortage of water as well as hygiene materials.

According to the camp dwellers, they obtain their health care either from the mobile team supported by NGOs or they visit the clinics outside of the camp, either private or public. Many of the male members of these camps are working outside the camp as unskilled labor during the day. This camp was not supported by any other NGO's for any materials as firewood or food supplies.

We visited the third encampment in the ruins of the former Soviet embassy building. The name is Khan e Elmu Farhang e Shurawi. There are estimated to be more than 220 family members living in this four/five story ruins of severally damaged building. There is no electricity. UNHCR has been provided 12 latrines for these 220 families after three years of this settlement. Obviously, not enough family latrines are maintained, as well as not having enough water supplies. As far as I could see there were two hand pumps in the perimeter of this housing compound. Again, there are no obviously malnourished children but obviously there is a serious hygiene problem among these children. Many male members are in and out of this compound suggesting that many of them are working outside of the camp during the day doing either menial work. Kinderberg International supplied the winterization materials last year but many of them are still living here either coming back from Pakistan or Iran or the internally migrated population after the earthquake in the northern part of Afghanistan two years ago.

Observation:

1. There is no impending need for medical treatment in this camp including supplemental feeding center for the children.
2. There is obviously a serious shortage of hygiene and lack of sanitation facilities. In the warmer seasons, there is an imminent threat for the outbreak of communicable diseases, if the lack of hygiene and water continues.

Even though many of the dwellers state that they are living there longer than a year, these are elusive population to keep track of. These are not typical refugees stay in the camp, rather they would move in and out often and difficult to assess what they really need. Even though they are coming from many different parts of the country, I am not certain whether they are the lower social cast in the pre-migration society of their origin. If this is an origin of longstanding illegal dwelling in major cities, the long-term project as well as education is crucial. Also, understanding of their social milieu in society is essential. Therefore, we will start with the simple distribution of essential materials primarily only hygiene materials including bar soap, basins, plastic containers and simple hygiene education.

Appendix M. Log

	DATE	AM	PM
	1/16 (Sun)	Cleveland to Detroit, NW Airline	Detroit to Frankfurt, Germany NW Airline
	1/17 (Mon)	Frankfurt to Stuttgart (Train)	Strategic meeting and briefing for Afghanistan project at Kinderberg International HQ
	1/18 (Tue)	Stuttgart to Frankfurt (Train)	Frankfurt to Dubai, UAE by Emirates
1	1/19 (Wed)	Dubai to Kabul by Kam Air flight	Met with office staffs Lai Thai
2	1/20 (Thu)		Visited ISAF camp for funding transaction for KBI
			German House
3	1/21 (Fri)		Inspection of pharmacy and check WHO Essential Drug list
4	1/22 (Sat)	Visited Dr. Hirabayashi UNICEF	Airport to pick up luggage German House
5	1/23 (Sun)	First staff meeting Met Dr. Akram, IbnSina	Container inspection Winterization storage inspection

6	1/24 (Mon)	Office workshop	Met deputy minister MOH, Dr. Nadra Dr. Latif at STEP German House
7	1/25 (Tue)	Field visit; Alokhel, Safed Sang	Lecture on HTN Met MRCA at their office Talked with Sunzana, KBI HQ Hospital interview survey for women (I)
8	1/26 (Wed)	Field visit to Abparam	Dr. Nihbrill, head of MOH, Logar visited us Discussed CHW final examination, graduation with Dr. Zahir Meeting at the Embassy of Japan Hospital interview survey for women (II)
9	1/27 (Thu)	Reviewed street children survey from dTh Visited Mr. Ahamadzi	Tabulated the results midwife survey at the hospital Met Dr. Ahctor, AWO
10	1/28 (Fri)		German clinic party
11	1/29 (Sat)	Mobile team to Abparan	Second survey at women's hospital by office staff Met with Mr. Petrocki, head of finance EU

12	1/30 (Sun)	Visited Alokhel village to meet with village chiefs	Assessment on returned refugee settlement by office staffs Observed winterization distribution at Safed Sang Visited 'returned refugee settlement'
13	1/31 (Mon)	Visited Sourkh Ab clinic	Met with Dr. Nadra, the deputy minister of public health Lai Thai
14	2/1 (Tue)	Visited Dashtak clinic Observe winterization in Dashtak	Met with the minister of public health Dr. Fatimi with Dr. Naib Khil, public health director of Logar province Discussed with Suzana, HQ
15	2/2 (Wed)	Visited Deh-e Naw Clinic Visit Ludin clinic	Meeting with Dr. Naib Khil Meeting with Dr. Abed, MRCA French restaurant
16	2/3 (Thu)	Met with Dr. Mustafa, head of grant and contract management Unit, MOH with Dr. Naib Khil, PHD of Logar province	Phone call to HQ, Stuttgart, Germany German House
17	2/4 (Fri)	Preparing for tomorrow's workshop	Preparing materials for CME conference next week
18	2/5 (Sat)	Office Retreat & Workshop (Lucky Town Restaurant)	

19	2/6 (Sun)	Final examination for CHW and graduation ceremony (Musayi clinic) Workshop with village chiefs at Alokhel	
20	2/7 (Mon)	Workshop in Dashtak	Discussed with HQ Met with Dr. Abed, MRCA Lai Thai
21	2/8 (Tue)	Meeting with mobile team AA proposal	Visited three resettlements for returned refugees Met with Dr. Latif, STEP Met with Dr. Akram, IbnSina Discussed with HQ
22	2/9 (Wed)	Met with village chiefs at Ludin Clinic Ludin CME conference	Lecture on basic epidemiology Work on AA grant b's place
23	2/10 (Thu)	Dr. Mustafa, MOH	Lecture on basic public health intervention Lecture on CHF Lecture on facilitation Met with Mr. Petocki, EC French restaurant

24	2/11 (Fri)	Draft final report	Check MMR and HMIS Check winterization program Shopping at Chicken Street
25	2/12 (Sat)	Discussed Naseem for future tabulation of mobile team data Discussed with Nabira for TBA data Discussed with Naseer for pharmacy statistics	Kam Air to Dubai, UAE
	2/13 (Sun)	Dubai to Frankfurt by Emirates	Met with Suzana Lipovac, general director of Kinderberg International for briefing of my trip and discuss future actions
	2/14 (Mon)	Frankfurt to Detroit by NorthWest Airline	Detroit to Cleveland by NorthWest Airline