merlin

KABUL EVALUATION REPORT

DRAFT ONLY

BY: Jonathan Patrick
and Hazel Simpson
1/4/96
EXECUTIVE SUMMARY

1. It is very difficult to get a good overview of the medical services in Kabul as not all are under the control of the MoPH, some being run by Hezb-i-Wadhat and others by numerous local and international NGOs. Working in health in Kabul there is the MoPH, two UN bodies, 19 international NGOs, seven Afghan NGOs, three Islamic groups, the Ministry of Defense and a couple of Commanders, many of whom are not particularly keen to share information and most are not interested to coordinate their activities. The MoPH are keen to coordinate health activities but lack cooperation from the players and while ACBAR is making a heroic effort it too lacks the cooperation and also the necessary technical manpower. Neither UNICEF nor WHO appear willing to take any responsibility for coordination.

2. Kabul is subdivided into 15 districts numbered one to 12 and 14 to 16. There are 19+ hospitals, 40+ clinics and over 25 MCH clinics, 60 mini health centres, numerous basic health centres in Kabul city alone in addition to a central blood bank. There are also thought to be numerous undocumented and unreported private and public health facilities in the city. No survey was carried out on private health care in the city but it appears that where no public facilities exist private health services are available.

3. MoPH run almost all of the MCH services and general clinics throughout the city. Hezb-i-Wadhat run a few clinics in the west of the city. The clinics are, theoretically, comprehensive MCH clinics offering curative services, under 5 and antenatal monitoring, and health education. AICF run feeding centres in 18 of the MCH clinics and MoPH with support from UNICEF have 16 fixed vaccination posts throughout the city. TDH are running a pilot midwife home visiting programme from 5 of the clinics.

4. UNICEF and MoPH work together to ensure EPI coverage in Kabul Province. Kabul City currently has 45 fixed vaccination centres and each district outside the city has 1. There is a plan to increase this number during 1996 and to train 65 mobile vaccinators in the villages. The fixed centres are all located in MoPH or Red Crescent MCH and polyclinics. MoPH feel they have enough staff to cover the EPI programme for the province and do not wish the involvement of the NGO's. Relations with AVICEN have deteriorated.

5. Both ICRC and MSF have good emergency capacity in Karte-se, Wasir Akbar Khan, Military and Jamhuriat hospitals. ICRC has emergency surgical supplies for 8 months under present security conditions. MSF has emergency surgical and drugs stocks for six months for 300 patients. MSF can also cope with cholera (500 patients) and measles epidemics in the city. Other agencies have buffer stocks for their own health facilities and can provide medicines and logistical support in an emergency although probably only ICRC and MSF are capable of taking the lead in an emergency response. At present no agency is collating basic health data and without this data it will be impossible for agencies to react in good time to any outbreak of disease. No agency has offered to take responsibility for data collation or dissemination.

6. All the health NGO's spoken to bring their drugs in from Europe. PSF have a large and comprehensive stock of drugs which they prefer to distribute via NGO's. UNICEF also provide kits to many of the health facilities. There are a large number of private pharmacies throughout the city and those visited by the team were well stocked with basic drugs although the pharmacists stated that it was difficult to get good stock into Kabul. The drugs were coming mainly from Iran, Pakistan, India and China.

7. While there were gaps in the current provision of services, many of these gaps were in preventative health care or else too disparate in scope resulting in a hoch poch programme filling gaps in a variety of geographical and sectoral areas. This raises the question, "Does Kabul need yet another international medical NGO or does it need better coordination and cooperation between agencies already working in the sector?" There is no work that MERLIN could do that another good NGO could not. It would better for NGOs already here simply to expand operations. Several NGOs have the logistical capacity and expertise to expand operations. Poor cooperation and coordination is the cause of many of the gaps in the current provision of services.
THE EVALUATION

Terms of Reference
1. Assessment of agency/NGO current activities in health and other related activities
2. Assessment of planned agency/NGO current activities for 1996.
3. Gathering of health information and data for the Kabul population relating to nutrition, vaccination, epidemic diseases, trauma, diarrhoeal diseases.
4. Assessment of respective government and agency capacities in curative, preventive surgical and MCH facilities/activities.
5. Evaluate levels of material supply provision and infrastructure rehabilitation.
6. Assess demographical issues re. IDP, returnees, potential population movements.
7. In the light of (6) assess the agency/govt. emergency preparedness.
8. Assessment of the security situation, current and potential future.
9. Assessment of requisite administrative aspects including availability of staff, salary levels, financial arrangements, registration, liaison etc.
10. Assessment of requisite logistical aspects including procurement, transport, accommodation, commodity and fuel prices, security arrangements (evac, medivac etc.) rehab requirements etc.

The Evaluation Team
Hazel Simpson is a nurse and has been working for MERLIN for sixteen months. She has previously worked for two years for Christian Outreach in the Sudan, and in Rwanda and Kandahar, Afghanistan for MERLIN. She is presently Medical Coordinator for MERLIN in Farah, Afghanistan.

Jonathan Patrick is an economist and has been working for MERLIN for three months. He has previously worked for SCF (UK), UNAIS and UNDP in Zambia, Pakistan, the Occupied Territories. He is presently Project Coordinator for MERLIN in Farah, Afghanistan.

Time Schedule
Arrival

<table>
<thead>
<tr>
<th>(JP)</th>
<th>Quetta - Islamabad</th>
<th>17/3/96</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Islamabad</td>
<td>18/3/96</td>
</tr>
<tr>
<td></td>
<td>Islamabad - Peshawar</td>
<td>19/3/96</td>
</tr>
<tr>
<td></td>
<td>Peshawar</td>
<td>20/3/96</td>
</tr>
<tr>
<td></td>
<td>Peshawar - Kabul</td>
<td>21/3/96</td>
</tr>
<tr>
<td></td>
<td>Kabul</td>
<td>22/3/96</td>
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<tr>
<td></td>
<td>Kabul</td>
<td>23/3/96</td>
</tr>
<tr>
<td></td>
<td>Kabul</td>
<td>24/3/96</td>
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<tr>
<td></td>
<td>Kabul</td>
<td>25/3/96</td>
</tr>
<tr>
<td></td>
<td>Kabul</td>
<td>26/3/96</td>
</tr>
<tr>
<td></td>
<td>Islamabad - Kabul</td>
<td>27/3/96</td>
</tr>
<tr>
<td></td>
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<td>28/3/96</td>
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<tr>
<td></td>
<td>Kabul</td>
<td>29/3/96</td>
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<tr>
<td>(HS)</td>
<td>Kabul</td>
<td>30/3/96</td>
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<tr>
<td></td>
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<td>31/3/96</td>
</tr>
<tr>
<td></td>
<td>Kabul</td>
<td>1/4/96</td>
</tr>
</tbody>
</table>
List of Agencies Working in Health and Related Sectors in Kabul (* indicates those visited)

ACBAR*  Agency Coordinating Body for Afghanistan Relief
AMI - A*  Aide Medical International - Afghanistan
ARCS  Afghan Red Crescent Society
ARF  Afghan Relief Foundation
AVICEN*  Afghanistan Vaccination & Immunization Center
HI  Halo Trust
IAM (Kabul)*  International Assistance Mission
ICRC (Kabul)*  International Committee of the Red Cross
IFCRS*  International Federation of Red Cross & Red Crescent Societies
IMC*  Internatioanal Medical Corp.
JWMM  Jacob's Well Medical Mission
KPRO  Kabul Province Reconstruction Organisation
MDM (Kabul)*  Medicines Du Monde
MMC  Mujahid Emergency Medical Center
MSF (France)*  Medicins Sans Frontiers
NAC  Norwegian Afghanistan Committee
ORA  Orphans Refugees and Aid
OV  Ockenden Venture
OXFAM*  OXFAM
PSF*  Pharmaciens Sans Frontiers
SCA  Swedish Committee for Afghanistan
SERVE  Serving Emergency Relief & Vocational Enterprises
SO  Shuhada Organisation
SOLIDARITY (Kabul)*  SOLIDARITY
TDH*  Terre des Hommes
UNICEF*  United Nations International Children's Fund
UNHCR*  United Nations High Commissioner for Refugees
WHO*  World Health Organisation

A. GENERAL INFORMATION.

Afghanistan is situated in the heart of Asia, whose geographical location makes it of strategic importance. It occupies about 650,000 sq kms of mainly mountainous terrain. Afghanistan has a population of 19 million including refugees abroad. The country has an annual growth of 1.4%. Exact figures are hard to come by as many Afghans now reside outside Afghanistan in Pakistan and Iran as refugees. Afghanistan also has a large unquantified nomadic population.

Kabul has a population of approximately 1,000,0001 down from 1.5 - 2 million three years ago before the current fighting.

A.1: PEOPLE AND POPULATION

1.1 People

Puushtuns are the largest group and are found mainly in the south of the country. Tajiks are the second largest group and speak Dari. Uzbecks in the north speak Uzbuki and Dari.

In Central Afghanistan Hazaras are the main ethnic group and speak their own dialect of Dari. Other ethnic groups are Turkmens, Baluch, Aimag and Nuristanis.

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1 Estimated from incomplete HABITAT data.
Pushtu and Dari are the official languages and commonly spoken. Uzbaki, Noristani, Pashai and Baluchi are also spoken.

The national religion is Islam, but there are small communities of Hindu and Sikhs. The majority of Muslims are Sunnis. There is a small Ismailis minority in the northern areas.

1.2 Military History

The emergence of the Taliban movement in 1994 gave hope to many Afghans in bringing stability and security to the country and particularly Kabul.

Their arrival in Kabul facilitated the removal of both Hikmatyar and Hizbe-e-Wadhat forces who had been fighting Rabbani in Kabul. The Taliban have been fighting in Kabul since. They are faced with an army better equipped and better trained than they had come across before. Attempting to break into Kabul the Talibs have caused high casualties including civilians in apparently indiscriminate shelling of residential suburbs. The Taliban siege of Kabul has created visible casualties apparent in the casualty figures from the fighting and the number of displaced people within the city. The war however has also created non-visible casualties unable to feed and warm themselves during the winter months.

So far Taliban troops have not been able to capture the city, though, like in the rest of Afghanistan it is impossible to predict the future with any confidence at all. Rocketing of Kabul continues daily.

A.2 DEMOGRAPHY

The following figures are those collected by HABITAT from surveys undertaken between September 1995 and February 1996. No indications of accuracy are given.

<table>
<thead>
<tr>
<th>District</th>
<th>Families</th>
<th>Population</th>
<th>% Children</th>
<th>% Disabled</th>
<th>Mean House Occupancy</th>
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<td>1</td>
<td>7896</td>
<td>44300</td>
<td>56.1</td>
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<td>13.0</td>
</tr>
<tr>
<td>2</td>
<td>9946</td>
<td>65885</td>
<td>49.2</td>
<td>0</td>
<td>15.7</td>
</tr>
<tr>
<td>3</td>
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<td>13595</td>
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<td>0</td>
<td>8.2</td>
</tr>
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<td>4</td>
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<td>n/a</td>
<td>n/a</td>
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<tr>
<td>6</td>
<td>18328</td>
<td>112268</td>
<td>52.9</td>
<td>0</td>
<td>10.5</td>
</tr>
<tr>
<td>7</td>
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<td>n/a</td>
<td>n/a</td>
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</tr>
<tr>
<td>8</td>
<td>7331</td>
<td>51103</td>
<td>52.8</td>
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<td>9</td>
<td>13295</td>
<td>121640</td>
<td>51.8</td>
<td>1.6</td>
<td>24.5</td>
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<td>n/a</td>
<td>n/a</td>
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<tr>
<td>11</td>
<td>5345</td>
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<td>1.0</td>
<td>15.1</td>
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<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
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<tr>
<td>15</td>
<td>36415</td>
<td>237600</td>
<td>52.2</td>
<td>1.2</td>
<td>13.7</td>
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<tr>
<td>16</td>
<td>9613</td>
<td>67941</td>
<td>52.1</td>
<td>0.9</td>
<td>10.5</td>
</tr>
</tbody>
</table>

Habitat figures indicate that there are marginally more adult females than males with males accounting for only 46% of the adult population. Children (under 18 years) account for 52.2% of the total population indicating a high natural rate of population increase.4

A.3 REFUGEE ISSUES:

Of a total estimated population of 1.5 - 2 million three years ago Kabul's population now stands at around one million indicating that there are approximately 500,000 to 1,000,000 Kabulis non-resident in the city. Many of these live as refugees in Pakistan and Iran though it is thought that a sizable number are internally displaced people, resident abroad not registered as refugees or else have gone back to their "home" provinces from where they originally came.

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2 Kabul is divided administratively into 15 districts numbered 1 - 12 and 14- 16.
3 Though not AICF figures. The difference though is unimportant.
4 HABITAT 1996 figures.
There are no figures for the number of Kabulis resident in Jalalabad or Pakistan nor are there figures for the number of refugees in Pakistan resident in the camps and in towns and cities. HABITAT monitor population movements into and out of Kabul.

From mid November 1995 (when data collection started) to early January there were an average of 5500 people leaving Kabul weekly mainly for Jalalabad and Pakistan with negligible numbers traveling elsewhere. From mid January to end February after which no figures are available numbers dropped to an average of 2000 weekly. During the same period through to end February 1996 there were far fewer returnees to Kabul with figures averaging 1000 a week for the whole period.

Earlier figures from April 1995 for returnees to Kabul indicate much higher numbers returning to Kabul. There were as many as 21,000 returnees in one week in May though the weekly average for April to mid June 1995 was 10,000. From mid June the number of returnees trailed off to a weekly average of 1000 by early November.

These figures indicate a clear net out migration during the winter months though because figures of departing Kabulis are unavailable until November it impossible to assess net flows before then. It is however likely that there was a net out flow over the summer as there was heavy fighting in the south of the city. The net out flow over the winter can be explained by the continued fighting in and around Kabul, though it is reported by both UNHCR and HABITAT that there is an annual seasonal migration from Kabul to Jalalabad during the cold winter months. UNHCR figures give no indication of reasons for in and out migration.

Many of Kabul's refugee population reside in Jalalabad with most of the remainder in and around Peshawar. As mentioned there is a net flow of refugees out of the city as of end February. HABITAT figures indicate that almost twice as many refugees are returning from Jalalabad than from Pakistan though no figures are available to suggest the respective total numbers of refugees in these two destinations.

In addition to the refugee population residing outside the city there is a sizable internally displaced population from the south of the city near the front line where most of the city is destroyed now living in the north of the city. This has lead to severe overcrowding in some districts (especially districts 2, 9, 11 & 15 - see mean occupancy per house figures above). Data suggests that houses in Kabul accommodate on average two families (mean family size = 6.8; mean house occupancy = 13.6). HABITAT estimate that 50% of the city is destroyed with much of the damage concentrated in districts south of the city which gives a biased estimate of the damage. One of the evaluators toured the south of the city near the front line and saw few buildings standing and few people in evidence.

District 9 on the other hand has an average of 24.5 people per house which with an average family size there of 9.1 indicates an average family occupancy of 2.7 per house i.e. severe over crowding.

A.4 SECURITY SITUATION.
The security situation in Kabul remains tense with daily rocketing of both military and residential areas. The aerial bombardment has temporarily ceased though it is thought that the rocketing will continue while the Taliband hold the south of the city. Wazi Akbar Khan is in the shadow of the rockets aimed at military installations just south (though one would be wise to remember that the Talibs are not renowned for their accuracy!) Many civilian areas in Sher-i-Nau and Wazi Akbar Khan (and of course elsewhere) have been hit by rockets and many people have been killed. All NGO and UN houses and offices are protected by sandbags though sandbags cannot be considered any protection from a direct hit. Similarly a bunker is only partial protection from a direct hit.

The security Team Leader in Kabul is responsible for UN staff security. UN security procedures are for UN staff only and take no responsibility for non-UN staff. The UN prepare weekly security

5 HABITAT collate weekly statistics of refugee population movements in and out of Kabul. They have a check point at Pul-i-Charkhi which monitors the destination of emigrants and the source of returnees. Data analysed here is aggregated for all migrant destinations and all sources.

6 HABITAT 1996 figures.
briefings which are passed on to NGOs. In the event of an emergency the UN Guest House is the regroupment centre and this house as a bunker. However the UN has no obligation to accommodate non-UN people or take responsibility for their land or air evacuation. In the event of a siege UN staff are recommended to remain in their bunkers or else go to the UN bunker. In the event of street fighting in the city UN staff are required to either evacuate if enough prior warning is given or else remain in their bunkers.

There have been reliable reports of robberies and kidnapping of UN local staff and UN property in Kabul city. Representation to the government has in the past resolved these problems after a number of days.

A.5 WHO'S WHO IN KABUL:

5.1 Government Officials
Minister of Planning: Mr. Zamani
Director of Department of International Affairs, Ministry of Public Health: Mr Zalmoudi Masoum
President of Basic Health Department: Dr. Derwish
President of Curative Health Department: Dr. Ahmedi
EPI General Director: Dr. Shukur

5.2 International Government Reps
British High Commission, No British Resident (affairs managed from Islamabad)
EU Representative: Ewan McLeod, Peshawar.
ECHO Representative: K Reitfelt, Peshawar
USAID: No representative

5.3 UN Organisations
HABITAT. Satarzai, Tel: 30717
UNHCR. Terry Pitzner, Tel: 31611
UNICEF. Robert, Eng. Khalil; EPI and Drug Distribution: Mr Arif. Tel: 20840
UNOCHA. Alexander Thier, Tel: 22804
UNOCHA. Demining: Tahsin Disbudak, Tel: 22804
WFP. Ismail Omer, Tel: 33100
WHO. Dr. Daiem Kakar. Tel: n/a :- currently in Britain for 3 months.
Acting Representative: Dr. Asmati

5.4 NGOs:
(See Medical section)

B: MEDICAL INFORMATION

B.1 INTRODUCTION TO HEALTH CARE IN KABUL
It is very difficult to get a proper overview of the medical services in Kabul as not all are under the control of the MoPH, some being run by Hezb-i-wadhat and others by numerous local and international NGO's. Working in health in Kabul there is the MoPH, two UN bodies, 19 international NGOs, seven Afghan NGOs, three Islamic groups, the Ministry of Defense and a couple of Commanders, many of whom are not particularly keen to share information and most are not interested to coordinate their activities. The MoPH are keen to coordinate health activities but lack cooperation from the players and while ACBAR is making a heroic effort it too lacks the cooperation and also the necessary technical manpower. Neither UNICEF not WHO appear willing to take any responsibility for coordination.

With so many players the collection of data for this evaluation has been problematic with much of the information coming from interviews. Maps provided by HABITAT proved invaluable and they also had some excellent population data. UNHCR provided very useful refugee figures.

There is also a lot of confusion about which health facilities are still functioning after the recent hostilities. Services at each of the hospitals and between clinics vary greatly.

MERLIN Kabul Evaluation page 6
Medical Demography

No statistics for Kabul alone are available though national figures for mortality indicate very high U5 and U1 mortality rates of 257 and 165 per 100,000 respectively. WHO figures for maternal mortality in Afghanistan are 1700 (per 100,000) though UNICEF put the figure lower at 640/100,000. Mean life expectancy at birth at 43 years is one of the lowest in the world.\(^7\)

Kabul hosts a largely monogamous society with mean family sizes (and therefore children per mother) of around seven.\(^8\)

Structure of the population. Data from the AICF report\(^9\) indicate that half the Kabul population are under 16 years old with the mean age of 19.8 (s.d. = 16.4). Children under five comprised approximately 19% of the total population. There is population parity between the sexes in all age groups though in the age class 20 - 35 years there are markedly fewer males than females indicating either high war casualties or high male migration out of Kabul (or both).

Morbidity from a population surveyed by AICF\(^8\) the following distribution of diseases was seen:

<table>
<thead>
<tr>
<th>Age group</th>
<th>ARI</th>
<th>Diarrhea</th>
<th>Skin Diseases</th>
<th>Malaria</th>
<th>Hepatitis</th>
<th>Typhoid Fever</th>
<th>Others</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under five</td>
<td>54.5%</td>
<td>26%</td>
<td>6.5%</td>
<td>4.5%</td>
<td>1.5%</td>
<td>1%</td>
<td>6%</td>
</tr>
<tr>
<td>5 - 15 years</td>
<td>45%</td>
<td>16%</td>
<td>7.5%</td>
<td>15%</td>
<td>2%</td>
<td>1%</td>
<td>13.5%</td>
</tr>
<tr>
<td>16 - 49 years</td>
<td>41%</td>
<td>3%</td>
<td>11%</td>
<td>27%</td>
<td>5%</td>
<td>4%</td>
<td>9%</td>
</tr>
<tr>
<td>Over 49 years</td>
<td>21%</td>
<td>0%</td>
<td>10.5%</td>
<td>26.5%</td>
<td>5%</td>
<td>5%</td>
<td>32%</td>
</tr>
<tr>
<td>Total</td>
<td>48%</td>
<td>17%</td>
<td>8%</td>
<td>13.5%</td>
<td>2.5%</td>
<td>2.5%</td>
<td>10%</td>
</tr>
</tbody>
</table>

This survey was carried out in October/November 1995 and shows the expected high percentage of respiratory tract infections. The information was gathered by asking the interviewee if they had been sick within the last 15 days. Of those who said they had been ill 30% had not attended for medical consultation. Of those who did less than 30% attended public health facilities, the others seeking private medical care. No reason is given for this. Unfortunately there is no similar survey from the summer months. However comparison of the population affected by diarrhoeal disease can be made using WHO diarrhoeal figures collected from the main city hospitals. During one week in October these show a total of 42 cases of diarrhoeal disease. This compares with 2749 cases over a similar time period in July.

Data gathered by the team from an MCH clinic in Khair Khana District shows similar disease distribution.

WHO and MoPH stated that throughout 1995 no cases of measles were reported and only 14 of diphtheria and 3 of polio. TB is recognised as a major cause of morbidity.

B.2 HEALTH SERVICE OVERVIEW

Kabul is subdivided into 15 districts numbered one to 12 and 14 to 16. There are 19 hospitals, 40+ clinics and over 25 MCH clinics, 60 mini health centres, numerous basic health centres in Kabul city alone in addition to a central blood bank. There are also thought to be numerous undocumented and unreported private and public health facilities in the city.

It is very difficult first to identify the health facilities in the city and second to ascertain where exactly these facilities are. (Even those running the clinics sometimes do not know which district they are in). As such the following list of health facilities in the city districts should not be regarded in any way as definitive either in terms of coverage or accuracy. Information on services available at each facility is very difficult to find. Some are non-functioning, some are supported by the MoPH (no salaries, drug prescriptions for the bazaar, minimal services), some are destroyed (usually

8 HABITAT data from UNCHIS AFG/93/002 1996.
bombed and in varying states of repair), some are minimally supported by NGOs and other agencies (e.g. drug provision only), while others are well supported by agencies (drug supplied, most/all services for facility, good referral system etc.) The evaluators have described the type of facility and the state it is in if destroyed or non-functioning. It was not possible to find full details of each facility.

<table>
<thead>
<tr>
<th>District</th>
<th>Population</th>
<th>State of District</th>
<th>Supported Facilities</th>
</tr>
</thead>
<tbody>
<tr>
<td>District 1 (popln. 44,300)</td>
<td></td>
<td>Much of this district is destroyed</td>
<td>Central Polyclinic, Maiwand Hospital, Avicena Emergency Hospital. Asmaye MCH-MoPH, Ashuqan Itifak &quot;unit&quot;. 1 mini HC (Oxfam plan 3 MCH clinics.)</td>
</tr>
<tr>
<td>District 2 (popln. 65,885)</td>
<td></td>
<td></td>
<td>Jamhuriat Hospital, RB Maternity Hospital. Shahar Ara MCH. 1 mini HC</td>
</tr>
<tr>
<td>District 3 (popln. 13,595)</td>
<td></td>
<td>Much of this district is destroyed</td>
<td>Malalai Maternity Hospital. Jamal Mina MCH-MoPH, one/two others 2 mini HC's (Oxfam plan 3 MCH clinics.)</td>
</tr>
<tr>
<td>District 4 (popln. n/a)</td>
<td></td>
<td></td>
<td>New Aliabad Hospital, Red Crescent Hospital, Security Hospital, Maternity Hospital. Parwani Seh MCH-MoPH &quot;Khair Khana 1&quot; clinic- ARCS, Kartai Parwan clinic - ARCS. 2 mini HC's</td>
</tr>
<tr>
<td>District 5 (popln. n/a)</td>
<td></td>
<td>Much of this district is destroyed</td>
<td>Police Hospital, Khoshal Mina polyclinic. Khoshal Mina MCH-MoPH, Afshar MCH (destroyed), Durahi Paghman MCH (destroyed) Dashti Barchi BHC. 2 mini HC's</td>
</tr>
<tr>
<td>District 6 (popln. 112,268)</td>
<td></td>
<td></td>
<td>Various Hezb-i-Wadhat run health facilities. Karte-se Hospital, (Atta Turk Hospital old building), Charsad Bester polyclinic Gul Khana MCH-MoPH/AVICEN, Bibifatemath Zara-AVICEN Qalai Wazir MCH-MoPH/AMI, Qalai Baktyar MCH-MoPH/AMI, Karte-se MCH-MoPH/IAM, Allauddin MCH-MoPH, Deh Dana MCH-MoPH Karte-se clinic-ARCS, Bibi Fahemah Zara clinic + two MSF clinics. 9 mini HC's</td>
</tr>
<tr>
<td>District 7 (popln. n/a)</td>
<td></td>
<td>Much of this district is destroyed</td>
<td>Aqa Ali Shams MCH-MoPH/AMI (in destroyed area), Wasil Abad MCH (destroyed), Tangi Saidan BHC, Technicum clinic-ARC,Tangi Saidan BHP.</td>
</tr>
<tr>
<td>District 8 (popln. 51,103)</td>
<td></td>
<td></td>
<td>Karte Parwan MCH-MoPH/AVICEN, Qalai Shar Shahid MCH (destroyed) Rachmamina clinic-ARCS Shewaki BHC, Siya Bini clinic, Khoshi Parwan clinic, Sarobi BHC</td>
</tr>
<tr>
<td>District 9 (popln. 121,640)</td>
<td></td>
<td></td>
<td>Microryan 3 MCH-MoPH/AVICEN, Shash Darak MCH-MoPH/AMI, Yaka Toot BHC.</td>
</tr>
<tr>
<td>District 10 (popln. n/a)</td>
<td>This district is currently heavily populated</td>
<td></td>
<td>Wazir Akbar Khan Hospital, Indira Ghandi Hospital Bibi Mahro MCH MoPH/AMI, Wazir Abad MCH-MoPH/AVICEN, Nazo Ana MCH-MoPH/AVICEN Taimani clinic-ARC, Disabled clinic (MCH)- AVICEN, Deh Sabz BHC.</td>
</tr>
<tr>
<td>District 11 (popln. 38,476)</td>
<td></td>
<td></td>
<td>Khair Khana Hospital, &quot;500 Family&quot; RC clinic, Maryam Hospital MCH (private) and (possibly) one other.</td>
</tr>
<tr>
<td>District 12 (popln. n/a)</td>
<td></td>
<td>This district lies to the east of the city and is thought to have a small population. Arzan Qimat MCH-MoPH.</td>
<td></td>
</tr>
</tbody>
</table>
District 14 (popln. n/a) There was some confusion over the boundaries of this district but it was thought to be a new district consisting of several of the large villages to the North of Kabul. Karezi Mir BHC and (supposedly) six other clinics.

District 15 (popln. 237,600) Atta Turk Hospital, Khair Khana Polyclinic "Khair Khana 3" MCH-MoPH, and (possibly) six other clinics and four other MCH clinics.

District 16 (popln. 67,941) Deh Khudai Dad clinic- ARCS Arzan Qimat clinic.

B.3 HEALTH SERVICE FACILITIES

3.1 Hospitals and Polyclinics Although most of the hospitals below are specialised between them they provide all necessary referral services for the population. Surgical needs are thoroughly covered by ICRC and MSF.

The hospitals are as follows:

1. Kartse Hospital. This is the main ICRC hospital. This 250 bed surgical hospital was built in 1988 and is fully supported by ICRC. The maternity ward is also currently supported by ICRC though this is soon to be downgraded to the provision of surgical kits. PSF also currently provide medicines and medical equipment until the mid June. It has OPD facilities with medical support by MSF.

2. Wazi Akbar Khan Hospital is a 250 bed MoPH surgical hospital 80% supported by ICRC. OPD facilities are not ICRC supported. PSF have plans to provide medicines from May. Physical maintenance is carried out by GMS.

3. New Aliabad Hospital is alone in providing neurosurgery. It also has a general surgical ward and a urology department. It is supported by ICRC who intend to scale down its involvement. MDM provide support in the form of logistical items, medicines and medical equipment. PSF supply medicines until mid May and will continue its involvement funding permitting.

4. The Crest Hospital has 20 beds and specialises in thoracic surgery though surgery facilities and treatment are thought to be poor. ICRC are scaling down their support to the provisions of emergency surgical kits.

5. Emergency Hospital (Ebensina). This hospital is currently ICRC supported thought again they are scaling down support to the provision of emergency surgical kits. It has 30 beds and two surgeries specialising in laparotomies.

6. Jamhuriat Hospital is a 230 bed surgical hospital with two operating theaters, recovery rooms three surgical wards, emergency ward anesthetist department, pharmacy, blood bank and a 24 bed burns unit. It specialises in traumatic, thoracic, investigative and curative surgery. MSF has been supporting Jamhuriat Hospital surgical department in the form of medicines and medical equipment since 1992. They will continue their support in the foreseeable future. PSF plan to become involved in the supply of medicines and medical equipment and are currently providing ad hoc support to the X-ray department and laboratory. IAM is training surgeons.

7. Indira Ghandi Hospital This 200 bed hospital has surgical, malnutrition, internal medical and neo-natal wards and an OPD department. ICRC support the surgical ward on an ad hoc monthly basis. AVICEN provided support in 1995. AICF support the 15 bed malnutrition ward with food, equipment and staff training. An Italian NGO has submitted a proposal to ECHO to support the hospital. MSF plan to establish a burns unit at the hospital.

8. The Military Hospital is a 400 bed hospital under the Ministry of Defense. This well funded and run hospital mainly provides surgical facilities for military war wounded. ICRC supply surgical material and will continue to do so. MDM withdrew their support from the pediatric ward in Feb 1996 due to the poor cooperation of the hospital authorities.

9. State Security Hospital This 50 bed hospital is under the joint control of General Yaseem and the MoPH. It is a surgical hospital for the military, state security and their families. It has a good budget and good surgeons and is supplies with surgical materials by ICRC.

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10 Polyclinics offer all basic health services.
11 This list of hospitals originated at a meeting of health NGOs at ACBAR. This list however is not thought to be definitive and reference to other "hospitals" has been made in the report. There is no fixed definition of what constitutes a hospital with many regarding a basic clinic with IPD beds as a "hospital".
10. **The Police Hospital** despite its name caters mainly for civilians (85%). It has 50 general surgical beds and is heavily used due to its location in a heavily populated area. ICRC provides surgical supplies and medicines.

11. **Afghan Red Crescent Hospital** is a 60-bed hospital. It has ICRC support in the way of medical supplies.

12. **The Maimwand Hospital** has a 50-bed medical ward and a 20-bed malnutrition ward with ENT and plastic surgery facilities.

13. **Khair Khana Hospital** has 25 beds (officially 52). ICRC supports war-wounded cases but are intending to cease its support. PSF supplies medicines to the IPD and OPD.

14. **Malalai Maternity Hospital** has gynecology facilities. AVICEN provides medicines and medical supplies as well as doing limited rehabilitation. ICRC supplies dressing material and PSF supplies medicines.

15. **The Attaturk Hospital** has a 15-bed malnutrition ward and a 15-20-bed pediatric ward. It is currently located in Khair Khana while the MoPH rehabs the old building. PSF supplies medicines, ACF work in the malnutrition ward and MDM provides medicines and medical supplies to the pediatric ward as well as train staff. MDM hopes to increase the number of pediatric beds to 50.

16. **Central Polyclinic** has beds but no patients (as of mid-March). It is mainly OPD but with a small surgical clinic. ICRC has wound down its support except to the surgical unit to which it provides surgical dressings.

17. **The Health Clinic** is regarded as a hospital despite its name. It is located in the west of the city and began life as an OPD. ICRC is providing assistance with medical supplies.

18. **Nazoona Gynecology Hospital** This 60-bed hospital has good staff and is well run. It was founded in 1992 by the Afghan Relief Foundation. In 1995 it was supported by AVICEN.

19. **Noor Eye Hospital** has 50 beds and is fully supported by IAM.

The Central Blood Bank is supported by AVICEN who have a three-month contract with the MoPH to provide incentives, fuel and maintenance.

Karte-se, Wasir Akbar Khan, Military and Jamhuriat hospitals are the four main emergency hospitals. They are supported by ICRC and MSF. Both agencies have good emergency capacity in all four hospitals. ICRC has emergency surgical supplies for 8 months under present security conditions. MSF has emergency surgical and drugs stocks for six months for 300 patients. MSF can also cope with cholera (500 patients) and measles epidemics in the city.

Many of the hospitals and clinics have laboratories. PSF has the equipment for 10 laboratories for the main hospitals which it has yet to allocate.

All but Jamhuriat hospital are in some way specialised. However there is no effective referral system between the hospitals and many patients will simply go to either the nearest hospital or else one where they know someone (be it only a porter!). There is very poor transport between hospitals and while some NGOs support ambulances, it has been reported that these are abused by hospital authorities and fuel stolen.

Karte-se and Wasir Akbar Khan hospitals providing similar services and both supported by ICRC were previously on either side of the old front line (1994) when fighting was between Mudj groups. Now all hospitals are on one side of the front line though the front line may change at any time.

### 3.2 MCH Clinics

MoPH run almost all of the MCH services and general clinics throughout the city. Hezb-i-Wadhat run a few clinics in the west of the city. The clinics are, theoretically, comprehensive MCH clinics offering curative services, under 5 and antenatal monitoring, and health education. AICF runs feeding centres in 18 of the MCH clinics and MoPH with support from UNICEF have 16 fixed vaccination posts throughout the city. TDH are running a pilot midwife home visiting programme from 5 of the clinics.

AVICEN supports 7 of the MoPH clinics and have 2 of their own. The support to the MoPH is mainly drugs and technical support the MoPH, MCH Department.
AMI support 9 MoPH MCH clinics. The staff salaries are paid by MoPH but AMI provide incentives for a clinic supervisor who manages the clinic. Each clinic has 1 obstetrician, 1 pediatrician, 4 midwives and 2 TBA's. The services offered by these are: drugs for ARI and CDD, obstetric and gynecological consultations, under 5 and antenatal monitoring. There is no health education facility or treatments for other diseases.

ARC's clinics provide curative care and have a full time health educator trained in psychological counselling. IFRC are hoping to develop MCH facilities at these clinics.

OXFAM plan to rehabilitate and run 6 new MCH clinics in districts 1 and 3.

UNICEF/MoPH run 60 mini Health Centres spread throughout the city. These each have one doctor and one nurse and treat seasonal diseases. In winter they treat only ARI and in summer only diarrhoeal diseases. They also monitor for childhood malnutrition and provide nutritional education and BPS biscuits. It is hoped to integrate many of these mini HC’s into the MCH system during 1996.

Most of the clinics see 50 - 60 patients a day although some of the clinics in the more populated areas of Microryan and Khair Khana see up to 120 and the IAM clinic in District 6 is seeing on average 160 women and children.

3.3 District Facilities (outside the city).

Kabul Province is divided into 12 districts: Bagrami, Charasyab, Chardihi, Deh Sabz, Istalef, Kabul city, Kalakan, Mir Bachakot, Paghman, Qara Bagh, Sarobi and Shakar Dara. There have been two new districts (Farsa & Guldara) created in the north of the province though no new maps are available.

There are SCA and MoPH have clinics in all of the provincial districts of Kabul covering most, if not all, of the district population. SCA’s clinics have been set up as part of the Minimum Primary Health Care Plan for Afghanistan and they are now in the process of handing some these over to the MoPH.

PSF support some of the MoPH facilities with drugs and medical supplies. IMC run a district hospital in Qara Bagh District, north of the city.

In Paghman and Char Syab district MSF run First Aid posts and curative health facilities.

AMI plan to extend their activities to Kapissa and Parwan Provinces in July of this year.

B.4 KEY PUBLIC HEALTH ISSUES

4.1 Immunization Coverage

UNICEF and MoPH work together to ensure EPI coverage in Kabul Province. Kabul City currently has 45 fixed vaccination centres and each district outside the city has 1. There is a plan to increase this number during 1996 and to train 65 mobile vaccinators in the villages. The fixed centres are all located in MoPH or Red Crescent MCH and polyclinics. MoPH feel they have enough staff to cover the EPI programme for the province and do not wish the involvement of the NGO’s. Relations with AVICEN have deteriorated.

A mass immunisation campaign was carried out in 1995 and a repeat campaign is planned for June 1996.

AICF carried out a survey of the vaccination coverage in November 1995. Their results were as follows:

Women of Child-Bearing Age

12 Aged 15 to 45 years.
The study found that due to the low level of uptake of both TT2 and TT3, and the fact that many women were immunised post delivery only 6.6% of births were protected against neo-natal tetanus.

Only 30% of women interviewed stated that they went to health facilities during pregnancy.

For children under 2 years old.

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>Card</th>
<th>Card and History</th>
<th>Confidence interval</th>
</tr>
</thead>
<tbody>
<tr>
<td>BCG</td>
<td>66.2%</td>
<td>77.9%</td>
<td>+/-7.6%</td>
</tr>
<tr>
<td>DPT1/Polio</td>
<td>39.0%</td>
<td>75.5%</td>
<td>+/-7.3%</td>
</tr>
<tr>
<td>DPT2/Polio</td>
<td>31.0%</td>
<td>61.6%</td>
<td>+/-6.9%</td>
</tr>
<tr>
<td>DPT3/Polio</td>
<td>22.1%</td>
<td>42.7%</td>
<td>+/-7.3%</td>
</tr>
<tr>
<td>Measles</td>
<td>7.0%</td>
<td>14.9%</td>
<td>+/-3.9%</td>
</tr>
<tr>
<td>All vaccines</td>
<td>4.7%</td>
<td>14.1%</td>
<td>+/-3.5%</td>
</tr>
</tbody>
</table>

These results show a very low measles coverage rate but MoPH and UNICEF feel that the results are not accurate as there has been no case of measles in the last year and a half. They say that data from the mass immunisation campaign suggests a coverage rate of 88% and plan to repeat the survey in the next few months. MSF have an emergency response capacity in the event of a measles outbreak.

All the vaccine coverage rates are low. The main reasons were the lack of information and motivation on the part of both mothers and health staff rather than any inherent inaccessibility of the EPI service. As stated above UNICEF and MoPH feel they have enough staff to cover the EPI programme for the province and do not wish the involvement of the NGO's.

4.2 Nutrition

AICF results from their Nutritional Report (1995) indicate that global malnutrition rate for the under fives was 6.2% with 1.8% suffering severe malnutrition. No significant difference was found between the nutritional status of boys and girls.

Most affected were those children under two years old, raising the question of appropriate weaning practices. Those children most at risk were those under two's raised by an uneducated mother.

There was no significant difference between residents and internally displaced people, nor was there any statistical difference within each class.

The prevalence of chronic energy deficiency among women of childbearing age was relatively high at 15.6%\(^\text{14}\). As for children no significant difference was noted between residents and internally displaced people, nor was there any statistical difference within each class. No statistically significant relationship was identified between women’s education and rates of malnutrition nor between mother’s and children’s nutritional status.

While food supply in Kabul remains very good, food availability at the household level is poor. Wages for all categories of people are very low and with high prices and rapid inflation, purchasing power is very low. Typical coping strategies included selling assets, barter and borrowing money to cover every day living expenses.

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\(^{13}\) At 95% Confidence, though it is unsure what these intervals represent.

\(^{14}\) CED is defined as a BMI (body mass index = weight/height\(^2\)) of less than 18.5 Kg/m\(^2\).
CARE and Tear Fund are nearing the end of a winter relief food distribution programme which has provided food for much of the poorer population.

WFP run subsidised bakeries throughout the city providing 1x 400g nan per person per day for widow, disabled and other vulnerable people.

Attendance figures at the AICF feeding programmes suggest that the malnutrition rate has remained fairly constant over the winter. AICF hope to carry out a follow up nutrition survey in May. ICRC have recently carried out a survey but the results are not yet available.

4.3 Emergency Preparedness and Risk of Epidemics
The high population densities in much of Kabul and the low vaccine coverage rates make risk of epidemics of measles and other communicable diseases very high.

Both ICRC and MSF have good emergency capacity in Karte-se, Wasir Akbar Khan, Military and Jamhuriat hospitals. ICRC has emergency surgical supplies for 8 months under present security conditions. MSF has emergency surgical and drugs stocks for six months for 300 patients. MSF can also cope with cholera (500 patients) and measles epidemics in the city.

Other agencies have buffer stocks for their own health facilities and can provide medicines and logistical support in an emergency although probably only ICRC and MSF are capable of taking the lead in an emergency response.

The problem in an emergency involving an epidemic will be the collection and dissemination of data. At present no agency is collating basic health data and without this data it will be impossible for agencies to react in good time to any outbreak of disease. Some agencies will have data for their own clinics though none reported to have analysed it recently and none pass on their data to anyone else on a regular basis.

When asked by UNOCHA in a meeting, no agency offered to take responsibility for data collation or dissemination. The relevant department at the MoPH could not be contacted to ascertain whether they collate health data in a usable format, though it is thought that they do not.

4.4 MoPH Admin and Logistics
The MoPH is a sophisticated body with several internal departments including an International Relations Department headed by an intelligent and forward thinking Dr. Zalmi Masoon. He is keen to coordinate the international relief/development effort under a long term strategy though is having difficulty doing so due to the inward looking nature of many agencies.

Any intervention must be well coordinated with the MoPH under Dr. Zalmi Masoon and should support the MoPH structure and initiatives.

The MoPH however is relatively under funded (though better than Taliban MoPH) and has very limited resources to implement its programmes. It is unable to pay anything other than nominal salaries and has very limited drugs for its facilities. Any cooperation with the MoPH using their staff would probably involve the payment of incentives. Some agencies have not paid incentives (many for good reasons) and have experienced difficulties because of it.

B.4 OTHER EXISTING HEALTH SERVICES AND PLANS:

4.1 UN Health Facilities
WHO. The WHO office in Kabul is in a state of confusion without Dr. Daiem Kakar. It is currently under the leadership of Dr Asmati who has only recently taken up the post and so was unable to provide the team with much useful information or statistics. WHO support and run various training courses as well as organising a mass vaccination campaign each year. Currently they are not collecting or collating data from the other agencies or playing any role in coordinating health activities in Kabul or supporting the MoPH in this.

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UNICEF. UNICEF's main work is the EPI which they conduct jointly with the MoPH throughout the city and province. They also support the 60 mini health centres throughout the city and supply kits of drugs to many of the health facilities. This is not a regular supply. Like WHO, UNICEF are unwilling to coordinate health activities in the city though MCH activities are clearly in need of coordination and direction.

4.2 Some NGOs working in Health and Related Fields in Kabul,

1. **ACBAR**, Ross Everson, 137 Farukhi Wat, Shehr-i-Nau, Kabul. Tel: 33684.
   ACBAR are the NGO coordinating body for NGOs in Afghanistan. They have an office in Kabul which coordinates Kabul NGO work. ACBAR is a relative newcomer to Kabul though has been running its Kabul operations from Peshawar for many years. ACBAR hold sectoral coordination meetings as well as provide useful information on Kabul. ACBAR run its own surveys and will undertake surveys for NGOs for a charge. It offers a daily mail pouch to and from Peshawar, radio and SITOR communications between Kabul, Jalalabad and Peshawar and has a notice board for vacancies, for sale and wanted. It will also provide advocacy services to members. ACBAR is a vital contact for NGOs in Kabul.

2. **ARCS.** ARCS have several mobile/first aid dispensaries around the city.

3. **AICF**, Thomas Gonnet, Philippe, Gilles. Tel: AICF run feeding centres in 18 MCH clinics in the city and carry out nutrition surveys to monitor the status of the population. They plan to expand to 20 soon and possibly incorporate home visiting.

4. **AMI** - A. Anne Billez, Jean Bernard
   AMI support Barakibarak Hospital in Logar Province. They have plans to rehabilitate 10 MoPH clinics and to provide medical training. They run training programmes in collaboration with the MoPH to increase the capacity of staff at MCH clinics around the city. AMI hope to extend their programme in 1996. They hope that this will include the support of Health Services in Kapisa Province.

5. **AVICEN**, Dr. Karim, M Nasim, Eng. Yahya. Tel: 61091. Over the past 2 years AVICEN have provided medical and logistical support to the Indira Ghandi and Nazoanana Gynecological Hospitals. Currently they are providing technical assistance to the MoPH for EPI and run 8 MCH clinics jointly with MoPH. They also have two vaccination teams in Qalabagh and Shamane.

6. **IAM** (Kabul). Bruce Gibbs, Hans Ronnlund, Lisa Kingma, Leena Kaartinem. Tel: 25723
   IAM have been working in Afghanistan for 30 years. They support the Noor Eye Hospital which has recently opened a surgical eye department in Maiwand Hospital. IAM also have an education programme for the blind and a physiotherapy school in Wazi Akbar Khan hospital. Their MCH clinic distributes food rations and provides health education for mothers.

7. **ICRC** (Kabul), Michel Duraux, Babette Zoag.
   ICRC are fully supporting the Karte-se Hospital surgical hospital and Wazir Akbar Khan hospital as well as partially supporting 12 other hospitals with medical supplies and medicines. (see hospitals below). They are now concentrating resources in their two main hospitals (Karte-se & Wazir Akbar Khan) and at the Military Hospital though will be scaling down their support to the others. ICRC are trying to encourage the other NGOs to take over the support that they previously provided (not that many need encouraging). ICRC will continue to provide surgical kits to the other hospitals for their emergency preparedness. ICRC are not involved in MCH or OPD work. ICRC also run a preventative health programme surveying and building wells in residential areas. They are also involved in a joint chlorination campaign to chlorinate 100,000 wells in Kabul province. This stop gap measure was started in 1992/3 (?) after a cholera epidemic in the city.

8. **IMC**
   IMC run 30 bedded medical and surgical hospital in Qara Bagh, at the north of Kabul Province. The hospital provides comprehensive OPD, MCH and EPI facilities. It sees an average of 200 out patients per day with an average bed occupancy of 15-20. The hospital charges small fees for consultation etc. but does not charge for drugs. Drugs are provided by IMC with assistance from PSF. This hospital was visited by the evaluation team and is providing an excellent level of health care to the population in the north of the province.

   IFRC support the ARC. They have 9 clinics in Kabul city. They are soon to expand their operations in the country and shift their emphasis from curative to preventative health care. ARC clinics are treating 100,000 people in the country.
10. IRC. Carol Le Duc. (University Town, Peshawar. Tel: 844027)
IRC are not active in Kabul at present, but are currently undertaking an evaluation with ToR in Health Education which (Carol says) is likely to lead to a proposal to ECHO to undertake health education in district 2 to compliment Oxfam's similar work in districts 1 & 3. (IRC ToR also include examining urban agriculture and education)

11. MDM (Kabul). Sylvie Chazalon
In Kabul MDM are rehabilitating and equipping New Aliabad Hospital. They have setup a paediatric and genecology consultation in Maiwand Hospital and plan to support Ataturk Hospital in the coming six months aiming to establish 50 IPD beds in the old Ataturk building. They are also supporting the MCH clinic in Poli Sotkha where they are providing expat paediatric consultations twice weekly and are soon opening a feeding centre for 20 children and their mothers. In the Panjshir Valley MDM are rehabilitating Rokha MCH clinic and are rehabilitating and equipping Safed Cher MCH clinic. MDM do not provide staff with salaries or incentives

12. MSF (France) Raul Bonifacio. Tel: 30511
MSF work closely with the MoPH and other non-secular bodies working in health. They began operations in 1992 and have plans to stay in Kabul for the foreseeable future though will scale down their programme (how and where they will do this is not known). MSF support the Jamhuriat Hospital emergency room, operation theater, recovery room, surgical ward, burns unit, radiology dept., blood bank and pharmacy. MSF supports six clinics in outlying districts of Kabul providing medicenes, incentives and logistic support. Two clinics have IPD facilities and Paghman Clinic has facilities and staff to stabilise patients for referral. Since 1995 MSF have been running a health education programme in 80 schools with 100,000 school children. They are expanding their H.E. programme into an environmental health programme to include the provision of basic cleaning materials, water supply and latrines.


14. OXFAM. Jeff Eames, Sue Emmot, Tanya Power-Stevens?. Tel: 62783
Oxfam are active in environmental health with a major water and sanitation programme (Logar Water Supply project). They are linking their health education programme to the water and sanitation programme targeting women to involve them in decision making. The recent evaluation is likely to lead to Oxfam setting up six MCH clinics in districts 1 and 3 with a doctor and nurse in each. Final approval and funding have yet to be granted for this programme.

15. PSF, Christian, Guion. Tel: 20179
PSF supply medicines and medical equipment to six hospitals in Kabul (see hospitals below), six clinics and other institutions in Kabul and are rehabilitating the Central Pharmacy. They supply medicines to five district clinics in and around Kabul Province and plan to extend their programme over the next year.

16. SCA. No office in Kabul. According to the latest (unpublished) ACBAR report on NGO activities in Kabul, SCA operate 20 basic and comprehensive clinics in Kabul Province. One visited by the evaluation team had been handed over to the MoPH six months ago, while another was functioning well (supported by SCA) with many patients. Without having spoken to SCA it is difficult to ascertain their strategy or the level of actual support to their clinics, though it one could imagine that SCA are in the process of gradually handing over their clinics to the MoPH. In addition to their clinics they have 95 basic health posts of which 19 are run by women basic health workers. It is not possible to say which, if any, of these are mobile health posts and so how many basic health workers in total have been trained.

17. SCF (US) M Soie, Asmaie, Hashimi. Tel: 33476

18. SERVE. Serve have been operating various disabled rehabilitation centres in Kabul since 1993.

19. SOLIDARITE (Kabul). Mathias Luft, Antoine Deroide, Jean Piere Leclerc. Tel: 34600
Solidarites have four main programmes in preventative health and emergency relief. Their largest programme is water supply to 600,000 city residents. They run the sanitation (black and brown water) in seven hospitals (Maiwand, Jamuriat, Indira Gandhi, Aliabad, Khair Khana, Antany? and Malalai?). Solidarites work on the water network, deep & shallow well construction & maintenance and provision of hand pumps. They also distribute emergency supplies (stoves, fuel and blanket) to targeted families (20,000 this winter).

20. TDH. Cindy. c/o ACBAR office though with plans to move soon.
TDH run a pilot women's post natal home based health education programme in five MCH areas.

21. TODAI. Kenzo Nakagaw, Fazl Rahman, Bismellah Akbari. Tel: 20946
4.3 Private Sector Health Care.

Judging by the number of sign boards there are a large number of doctors, dentists and other health professionals practicing privately in the city. Many of the clinics are run by MoPH doctors who, in the morning, run MoPH clinics, but are unable to sustain themselves on their MoPH salaries alone. No survey was carried out on private health care in the city but it appears that where no public facilities exist private health services are available. The quality of this private service is unknown nor are the facilities or range of services offered.

B.5 OTHER ISSUES:

5.1 Drug Supply

All the health NGO's spoken to bring their drugs in from Europe. PSF have a large and comprehensive stock of drugs which they prefer to distribute via NGO's. UNICEF also provide kits to many of the health facilities.

There are a large number of private pharmacies throughout the city and those visited by the team were well stocked with basic drugs although the pharmacists stated that it was difficult to get good stock into Kabul. The drugs were coming mainly from Iran, Pakistan, India and China.

PSF recently checked the quality of some of the drugs, the results of which are available to all the NGO's.

Most of the NGO's and MoPH provide all services and drugs to the patients free of charge. This appears to be true even of SCA although they are implementing partners for the Minimum Primary Health Care Plan for Afghanistan.

5.2 Household Survey

As part of their nutritional survey in Nov. 1995 AICF conducted a household survey which deserves a mention. AICF conducted a two stage PPS\textsuperscript{15} cluster sample on heads of households in administrative subdivisions of Kabul.

Half the sampled population in all subdivisions reported to be residents while the other half were internally displaced people (IDPs). Of the residents, 20% were returnees from around Kabul and Jalabad. Two thirds of IDPs were long term residents with an average stay of two years. AICF reported that IDPs had been displaced on average twice and that most of them were displacees from within the city rather than from other areas of the country.

While 82% of residents owned their own houses, less than 7% of IDPs were homeowners. 82% of houses had access to private latrines and 10% had access to shared facilities with the remaining having access to non-functional flush toilets. Mean house size was two rooms and mean family size was six.

Most people relied exclusively on the local market for their food. Only in a few cases did households have access to a plot of land on which to grow food or rear poultry or animals. The majority of families reported that they had no food stock in the house relying instead on daily food purchases.

While only 5% of households stated that they had no source of income, the majority stated that the income they received was not enough to live off and had to resort to other coping strategies. These coping strategies included selling assets, borrowing money and small businesses. There were no reported differences between IDPs and residents in either income level or rate of employment. However IDPs did have to cover house rental and other related costs and as such were more likely to resort to selling assets and borrowing money than were residents.

\textsuperscript{15} Population Proportional to Size.
The results indicate a large number of IDPs in the city living in cramped rented accommodation unable to afford the basic family food basket. Many (40%) were resorting to selling family assets while most (69%) were resorting to borrowing money from relatives, friends and businesses.

**B.6 POTENTIAL MEDICAL / PUBLIC HEALTH PROJECTS:**

The general feeling among the NGOs is that there are already too many health NGO's in Kabul and the work is covered. MoPH are also reluctant to add to their already large case load of agencies to coordinate inside Kabul City and so proffered little information about the work within the city. They were keen for MERLIN to become involved in provincial districts or other provinces around Kabul but most of the areas mentioned were already fairly well served with health facilities.

The only agencies who suggested that there may a role for MERLIN with in the city was AVICEN and IFRC who both pointed out that the distribution of health facilities does not relate too closely to the current distribution of the population.

While there were gaps in the current provision of services, many of these gaps were in preventative health care or else too disparate in scope resulting in a hoch poch programme filling gaps in a variety of geographical and sectoral areas.

One can also put the question, does Kabul need yet another international medical NGO or does it need better coordination and cooperation between agencies already working in the sector. There is no work that MERLIN could do that another NGO could not. Given the high logistical cost of setting up a programme it would better for an NGOs already here simply to expand operations. Several NGOs have the logistical capacity and expertise to expand operations, but none have identified gaps that they could fill. Poor cooperation and coordination is the cause of many of the gaps in the current provision of services.
C. ADMINISTRATIVE INFORMATION

C.1 LOCAL STAFF:

1.1 Availability of local staff:
There appears to be good availability of Afghan staff for the kinds of work an NGO is likely to need. Many Kabulis are well educated and many have reasonable, if not very good, English. Kabulis are the best educated Afghans. Most people thought that good Afghan staff would be reasonably easy to find. Many aspirant NGO workers apply to ACBAR in the hope of getting work in the NGO sector. (ACBAR currently has many applications and resumes) and will advise NGOs on people it has on it books. It is possible to employ women in all fields of work.

1.2 Salary levels:
The following represents the result of a recent salary survey conducted by ACBAR in mid February 1996. (US$ = Af8000)

**Medical Staff**
- Doctors: Af$ 600,000 - 2,000,000
- Pharmacist: Af$ 550,000
- Nurse/Midwife: Af$ 300,000 (NGO incentives + Af$ 80,000 MoPH salary)
- Hospital Administrator: Af$ 450,000 ( + Af$ 110,000 MoPH salary)

**Non-Medical Staff**
- Project Manager: Af$ 1,000,000 (ACTED)
- Programme Officer: Af$ 1,500,000 (ACBAR)
- Chowkidars: Af$ 200,000 - 440,000
- Drivers: Af$ 300,000 - 500,000

Most NGO staff receive other benefits like meal allowances (up to Af$380,000 for a PSF chowkidar) holiday bonuses, travel allowances, health insurance / treatment etc.) An ICRC survey indicated that the minimal nutritional requirement for a family of six costs Af$ 300,000 in February 1996. The cost of living for the same family of six in February was estimated at Af$ 600,000 (food, shelter, clothing etc.) ICRC regularly monitor the cost of living and the cost of providing the minimal nutritional requirements. They make their findings and an index of the cost of living available to NGOs.

ICRC paid the highest salaries and offer the most contractual benefits. (UN organisations were not surveyed).

ACBAR thought that while it is relatively easy to find English speaking staff it would be more difficult to find computer literate staff.

Many NGO have female Afghan staff in both medical and non-medical roles. There is no prohibition against the employment of female staff and employing women presents no more that the usual problem in any Islamic country. There are a good number of well educated women in Kabul available for work.

C.2 LIVING CONDITIONS.

2.1 Accommodation.
Most NGOs and UN agencies have their houses and offices in Shehr-i-Nau and Wazi-i-Akbar-Khan. Shehr-i-Nau is generally thought to be safer than Wazi-i-Akbar-Khan as the latter lies just behind the Presidential Palace which is a regular target of the Taliban heavy weapons. Rents are a little higher in Shehr-i-Nau (approx. US$ 300 - 500 a month for a four bedroomed house) than Wazi-i-Akbar-Khan where the same house would fetch approx. US$300 a month. There are many beautiful houses in Kabul and securing one should not be difficult. There are several property agents in Kabul who, for a commission, will find a suitable house. However property agents tend to inflate the price of the houses they offer so it will be worth shopping around.
All houses in these two areas are European style with European kitchens and bathrooms. Typically, a four bedroomed house would have a living and dining room, downstairs toilet, a driveway and many have small gardens. All houses come unfurnished and generally need little rehabilitation. Those needing extensive rehabilitation are cheaper.

For security, any house and office should have a basement beneath the house (or a substantial garden structure) which will double as a bunker during shelling. Most NGOs have their windows sandbagged and plastic film placed over the glass to prevent injury from flying glass. Most houses have at least one window (usually many more) that has been shattered from a recent shell exploding nearby.

2.2 Office.
Many NGOs operate both a house for expatriates and an office. There are no distinct "office" buildings as opposed to "houses". It should be possible to rent both a house and an office in the same compound though if this is not possible then it would be wise to rent both a house and office in the same district as traveling between Shehr-i-Nau and Wazi-i-Akbar-Khan can present a security risk during air raids and at night when there are many military checkpoints in the city.

2.3 Climate.
Temperatures in Kabul can drop to minus 20 degrees centigrade in winter and rise to the late thirties in summer. Dust is not a major problem though clearly snow and ice affect driving conditions in winter. Houses are heated by paraffin stoves which are effective as space heaters though some can smell heavily of fuel.

2.4 Finance.
Many NGOs use the Kabul money lenders/changers to transfer money into the country. Cash is given to NGOs in Kabul in small denomination notes (Af5000 notes) while they are paid in Peshawar in large denomination notes. The difference in the exchange value of the different denomination notes is the money changers commission for the transaction. Cheques in either Pakistani Rupees or US dollars drawn on a Grindlys account can also be presented to Kabul money changers by prior arrangement and will be honored in Afghanis at the current exchange rate minus a small commission (usually one percent).

This system works on trust so NGO must be introduced to a reliable money changer who in turn will require an introduction by a trusted NGO.

In the absence of this system NGOs will have to operate an account in Peshawar and fly regularly to withdraw money. It is not thought advisable to hold large amounts of cash in Kabul as robbery (including armed robbery) is not unknown. "Large" is anything more than an NGO can afford to lose.

2.5 Facilities.
The city has no electricity at present except in one outlying district, Khair Khana. There are plans to extend the grid to other areas including Shehr-i-Nau and Wazi-i-Akbar-Khan and at presents. However most (if not all NGOs) operate their own generator. A 15kva generator was thought by some to be a reasonable minimum for a medium sized office / house with several computers, a water heater and a water pump running off it. There are no new generators for sale in Kabul. Many are presented as "new" though closer inspection will reveal years of previous use. Second hand Russian and Chekoslovakia made generators are available as are their spare parts. Many generators are cut and pasted from other non-functional generators so beware. Importing one will involve either great risk (the overland route from Pakistan) or great expense (air freighting it from India with ARIANA).

Like electricity there is presently no piped water to Shehr-i-Nau and Wazi-i-Akbar-Khan though there are plans to supply piped water to these areas. All houses have their own wells in the compound and water is pumped up to roof tanks daily.

There is no sewage disposal system in Kabul and each house will have its own septic pit which is pumped out when required. With relatively small gardens home to both a well and a septic tank there is clearly scope for seepage from one to the other and so wells will need to be checked regularly for pollutants.

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Kabul has its own anarchic telephone system which operates within the city. There have been no new lines installed for several years so should a house not have a line it has no possibility of having one installed. Telephone lines rely on electricity to work so with the mains power off the lines are dead. (The central exchange is wired to the mains electricity grid). Kabul offers the usual choice of local food items. Kabul also has the famous Chicken Street where, for a price, many imported food items can be bought. Pakistani newspapers and other international magazines can be bought in Kabul. These are imported from Pakistan. New satellite dishes and s/h televisions can be bought in Kabul and videos and cassettes are available.

There are two main clubs for expatriates. The UN Club offers a bar and squash and swimming facilities while the German Club offers tennis but no bar. There is a nightly bar at ICRC with Thursday night the night to see and be seen! AIM hold Pancake nights every Thursday which are good English speaking social events. Pancakes are eaten on a hymn and a prayer!

There is no library in Kabul. Good maps of the city can be bought from the government Department of Cartography near the Ministry of Finance. Maps can also be obtained from HABITAT who make their own maps. They have a good selection of both general and specialist maps of interest to sectoral (inc. medical) NGOs.

C.3 WORKING ENVIRONMENT

3.1 Office Week and Hours.
Most offices open Saturday to Thursday (or Wednesday). Hours are generally 08.00 to 16.00 with a half day on Thursday. Most UN agencies open five days a week as does ACBAR. Most health facilities are open until 12.00 or 13.00.

3.2 Attitude of the Authorities.
The authorities in Kabul (Min of Planning, MoPH, Min of Foreign Affairs) are thought to encourage international NGOs and are keen to coordinate all health activities under a "master plan" for Kabul.

All NGOs require to be registered with the Ministry of the Foreign Affairs. Unlike in Pakistan, this is a relatively straightforward form filling exercise. However, the same ministry and the MoPH also require NGOs to sign a protocol agreement which among other things requires the NGO to hand over all its assets at the end of the programme to the ministry. The protocol could be interpreted to cover expensive communications equipment and vehicles. Three NGOs have so far signed this protocol though the remainder have not. Should MERLIN start a project it is advisable that it does not sign the protocol as it now stands!

3.3 Working with Women/Gender Issues.
There are no restrictions placed on the employment of women by the authorities. There are many educated women in Kabul available for work and many working in the NGO (and other) sector. Kabuli women appear much less oppressed and isolated than those in Taliban areas. Few women are seen wearing a full burqa and many wear western dress. Women are more visible in the streets than in Taliban areas and have access to most public facilities (hospital etc.). Many women work in low paid jobs in NGO houses as cleaners and cooks.

Many expatriate women drive in Kabul though walking alone is not considered safe in the main bazaar. Few (if any) expatriate women wear the shalwa camise.

3.5 R & R.
Despite intermittent daily shelling of the city Kabul is a fairly relaxed place on the whole. There are many expatriates (around 80) for like minded company after office hours. There is the UN Club and the ICRC bar for evening entertainment.

Daily shelling is likely to fray nerves a little so for more formalised R & R away from the city, Peshawar is only a short (1 hour) flight away by the ICRC plane. An agreement could be reached with an NGO in Peshawar for accommodating expatriates on R & R breaks as well as work related trips. Any arrangement would necessarily involve crossing palms with silver (well tatty Pak rupee...
notes at least). Indeed it would be well worth while setting up a liaison / procurement / R&R office in Peshawar under the umbrella of another (registered) NGO or else setting up a joint office there with another Kabul based agency.

Should procurement prove necessary from India then again it might be worth setting up a small office/house in New Delhi with another like minded agency. Return Kabul - New Delhi - Kabul flights are US$360. New Delhi is a much better place for R&R than Peshawar though an office/house there cannot be justified unless a procurement base in India proves vital.

3.6 Liaison.
Most NGOs working in Afghanistan have their head office in Peshawar. Few of the Kabul agencies do not have some sort of representation in Peshawar and MERLIN would do well to follow suit. However an independent staffed office in Peshawar would be hard to justify particularly considering MERLIN already has a non-programme office in Quetta. More likely would be an arrangement with another NGO whereby MERLIN can use a guest house and has access to a phone and fax and has a postal address. No satfax would be needed. Messages to and from an expat there could be sent via UNOCHAs radio or through the (soon to be installed) ACBAR SITOR HF radio telex. (MERLIN would probably have to become a member of ACBAR to use their facilities on a regular basis).

D. LOGISTICAL INFORMATION

D.1 PROCUREMENT AND REHABILITATION

1.1 Procurement
Non-Medical Most food items appeared to be available in the bazaars and shops from potatoes to Belgium chocolate. Second hand and new furniture is available and the city has several electrical shops. New generator are impossible to find though rehabilitated Russian generators are relatively easy to find. Antiques can be found in abundance in Sher-i-Nau. Prices clearly rise when the city is blockaded though fall again when the blockade is lifted. Kabul city itself has no agriculture to speak of and most agricultural produce is brought in from the north. During winter prices rise due to the relative scarcity.

Medical No medical equipment survey was done though there appeared to be several pharmacies in the city. Most NGOs procured their drugs from abroad and no cost recovery was practiced by any.

1.2 Commodity, Food and Fuel Prices.
Diesel can be bought at road side sellers for Afs 22,500 a gallon. Food availability in Kabul is relatively good with most food products available in the bazaar and shops. However the high prices for food and other items relative to incomes ensure food scarcity at the household level for many Kabulis. While unemployment remains low at less than 5% the low wages paid in the public sector and for non-skilled labour averaging Afs 65,000 including food allowances means that additional income is required to meet the cost of the minimum food basket which for a family of six is priced at Afs 170,000.16 Skilled labour and private businessmen earning an average of Afs 130,000 were better placed to feed their families though additional income still must be sought. In the month prior to the AICF survey (i.e., October 1995) one third of families had sold household items and almost two thirds had borrowed money to finance daily expenditures.

D.2 TRANSPORT AND COMMUNICATION

2.1 Vehicle Rental.
Vehicles (4x4 and 2x4) can be rented fairly easily in Kabul. "Park Car Sellers" in Shehr-i-Nau will rent good quality vehicles with or without drivers. Prices (without drivers) are:

<table>
<thead>
<tr>
<th>Type</th>
<th>Price</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minibus</td>
<td>US$ 700</td>
</tr>
<tr>
<td>Big 4x4</td>
<td>US$ 700</td>
</tr>
<tr>
<td>Saloon car</td>
<td>US$ 500</td>
</tr>
</tbody>
</table>

16 AICF report Nov. 1995 (US$ = +/-Afs 5000)
These prices are high and it would be possible to rent cheaper elsewhere. Old UN vehicles can be donated to NGOs though they are sometimes of questionable quality. There are good vehicle mechanics in Kabul so maintenance and repair should present no problem. Most NGOs in Kabul own their vehicles and others simply rent taxis for around town. Taxis can also be hired on a long term basis (Afs 80,000 daily plus driver salary and fuel). Fuel however is expensive (cheaper in Jalalabad).

2.2 International Air Transport.

ICRC: ICRC currently make long round trips to various destinations in Afghanistan. You travel with the plane until your destination and then simply get off. (A bit like a bus). ICRC have several flights weekly stopping at Kabul. On all flights NGO international staff can fly for free, but numbers are limited and priority until the last minute is given to ICRC, IFRC and UN officials. The flight itself is also liable to cancellation in bad weather (rain and poor visibility at destination). Reservations must be made in writing to ICRC Peshawar by the Tuesday preceding the next Saturday-Thursday week, and confirmation is only given on the Thursday before the week. All passengers must have valid Afghan visas.

UNOCHA: The UNOCHA (Salaam Ops) plane flies regularly between Islamabad and Kabul every Monday and Thursday and costs $380 return. The plane will land in Peshawar if there are more than two passengers wishing to alight or disembark there. The plane flies via Jalalabad both into and out of Kabul. Bookings must be made in writing to UNOCHA in Islamabad before the Thursday preceding the Saturday-Thursday week. UN have priority until the last 48 hours, then it's first come first served. Cancellation must be more than 24hrs in advance. Obviously, it will be more reliable to use these scheduled flights, although they can be canceled if there are not enough passengers. However once confirmed on the flight you are unlikely to be bumped off by other UN or other passenger wishing to fly. Like with ICRC the flight is liable to cancellation in poor weather conditions. All passengers must have valid Afghan visas or will not be allowed on the plane.

ARIANA: At present there is no ARIANA commercial flight between Peshawar and Kabul. There are however ARIANA flights between Kabul and Jalalabad and from Jalalabad to New Delhi (US$360 rtn.) and Tashkent. Its Dubai operations were suspended when its plane there was grounded by the Taliban authorities in Kandahar.

AFGHAN MILITARY: The Afghan military will allow you to hire their planes for freight transport to government held areas. Many NGOs are reluctant to do this for fear of being too closely allied to the government.

2.3 Freight.

Forwarding freight (especially electronics) from Peshawar in Pakistan involves a lot of time and a lot of red tape. Many NGOs have now abandoned the attempt and have switched their procurement source to India. ARIANA fly direct to New Delhi from Bagram and Jalalabad. ARIANA also fly to Tashkent but no longer fly to Dubai. The UN allow NGOs to charter their aircraft for US$2000 for the round trip Islamabad-Kabul though with a payload of only one tonne this works out at US$ 2 per kilo. Baggage is normally charged at US$1.25 per kilo in excess of 15 kilos baggage allowance per passenger for the Islamabad-Kabul run. The transport of excess baggage on the same flight as the passenger is subject to available space though once the goods have been accepted, Salaam Ops will eventually transport the items.

There is a cold store in central Kabul at the WHO office.

2.4 Overland Transport.

There is an overland route open between Peshawar and Kabul. Traveling this route via Jalalabad requires first a No Objections Certificate (NOC) from the Pakistan Kyber Agency and a letter of recommendation from the Afghan Nangarha Affairs Office in Peshawar. This letter is given to the authorities at the border in Nangarhar province and armed guards are provided for the trip as far Kabul. However this trip is considered a little dangerous as territory crossed is controlled by quasi independent commanders whose forces do not think twice about robbing vehicles of their loads. Travelers should consult first with UNOCHA about the latest security situation and should obtain permission from local commanders who can provide armed escorts. NGO stickers and flags are some protection though expatriates are not thought to be at risk though expatriates have been killed.
in Jalalabad. Most expatriate staff prefer to fly and some NGOs refuse to allow their vehicles to cross this route. This route can also be traveled by public transport (easier for women in burka!)

The routes south and west across the front lines are passable though most agencies do not cross them. The risk is less from being targeted than from being hit in the crossfire.

Because of the lack of land transport into and out of Kabul, the city has a siege town atmosphere. Trucking goods into Kabul is very difficult and so bulky items must be bought here or else ordered and paid C.O.D. at inflated prices. Only small light items can be flown in with the UN and ICRC planes.

The overland route to Kandahar takes two (good) days if not three and involves crossing the front line (obviously). This route should only be crossed in convoy and with the prior agreement of the Taliban. The UN Security Team Leader can advise on crossings.

2.5 Communications.

Officially all radio equipment needs to be registered with the Ministry of Communications. This requirement however is not adhered to by most NGOs. The Ministry of Communications however does not appear to be too concerned about the use of radio equipment and does not dictate which frequencies can and cannot be used.

The ICRC, UNOCHA and others use a HF telex (SITOR) which MERLIN perhaps ought to investigate. This system is simply an addition to the standard Codan and so can be used in conjunction with sel-calls.

HF radio contact is good from Kabul to most places in Afghanistan and northern Pakistan from a base station.

The UN operate a VHF repeater station on one of the hills in Kabul. This repeater can be used only by certain frequencies the use of which only the UN themselves can sanction. Without a repeater station the range of VHF radios is limited to within the center of the city. Many NGOs use special long antennas on their VHF handsets due to the poor VHF reception in the city.

While most NGOs in Kabul do not have either HF radios or a satellite fax/phone it would be prudent for MERLIN to do so should it come to Kabul. MDM recoup some of the cost of their Satphone by allowing other NGOs to use it at a cost of US$10 per minute. MSF also allow their satellite fax and phone to be used by other agencies. They charge US$10 per minute on the phone, US$10 per page of printed fax material on the B-system and US$8 per page on the C-system. (JP suspects this is somewhat above the billing cost of using the system and constitutes a nice little money earner!)

The post office operate an international telephone line for which the charge is US$10 per minute. MDM operate a satellite fax and telephone which they allow other NGOs to use also for US$10 per minute. There are no regulations governing the use of satellite faxes or phones.

2.6 Visas.

All passengers flying into Kabul and the rest of Afghanistan require valid visas. These can be obtained at the Afghan consulate in Peshawar. Expatriates should not attempt to get their Afghan visa from Taliban held areas of the country as passports containing Taliban issued visas are liable to confiscation by the Afghan government authorities in Kabul.

All passengers for Peshawar and Islamabad require a Pakistani visa before arrival. However since the torching of the Pakistani Embassy in Kabul last year (1995) the Pak embassy there has been closed. Pakistani visas can be obtained in Jalalabad. Passengers for Pakistan will therefore need to think well ahead if they wish to travel back to Pakistan from Kabul.

All foreigners now require a "Stay" visa if they are staying longer than a week. Foreigners also require a "Exit Permit" to leave the country. This permit should be obtained two days before departure.

2.7 Mail.

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All NGOs send and receive mail via Pakistan. An NGO will either have mail sent to their head office in Peshawar (ACBAR) or to a sister or friendly organisation with an office there who will forward mail into Afghanistan and out of Pakistan. For its members ACBAR offer a daily mail pouch between Peshawar and Kabul. Mail needs to be delivered to and collected from the ACBAR offices in Kabul and Peshawar. (MERLIN's Quetta office does not have to access to the ICRC office in Peshawar to act a mail forwarder for a Kabul office.) The post office in Kabul does forward international mail, but is sufficiently slow and unreliable to be of curiosity value only. (MERLIN could post its weekly sitreps!)

D.3 PRACTICAL SECURITY ARRANGEMENTS

3.1 Coordination
UNOCHA provide written daily security briefs and weekly military updates. Terry Pitzner of UNHCR is responsible for UN security and will keep NGOs informed of the security situation though does not hold regular security meetings with NGOs. The UN have elaborate security procedures which obviously cannot be given here though are available on request from the UN. Any MERLIN project would do well to coordinate with the UN though not to rely on them but have their own arrangements.

3.2 Evacuation
Evacuation overland through Jalabad to Peshawar is safe though obviously thorough checks will need to be done before this route can be attempted. Air evacuation would normally be by ICRC or UN planes, which give priority to their own staff. The UN think that they would not keep the UN plane in the air to evacuate NGO staff members after UN staff have been evacuated.

3.3 Medivac
ICRC will undertake to fly sick or wounded expatriates to Peshawar for treatment at the main ICRC hospital there. Hospitals in Islamabad and Karachi (Aga Khan) are thought by some to be better. UNOCHA Demining operate ambulances to Peshawar for injured deminers and could transport expatriates this way also.

3.4 Roads and Checkpoints
Roads in Kabul are generally very good (compared to Kandahar and Farah). During the day there are no checkpoints in the city though once out of the city there are many check points. Crossing them presents no problem though the usual rules apply (drive slow approaching them and always stop). There is a fairly strict 10 pm curfew in the city after which it is inadvisable to travel. During curfew there are many checkpoints and extreme caution should be exercised if traveling. Drive very slowly with headlights dipped and the cab light on. Always stop at check points. Carrying a supply of cigarettes and biscuits etc. for the soldiers will smooth the way. They are very nervous at night.

3.5 Front line
Darolaman area in the south of the city is considered very dangerous and the front line just beyond is not considered passable.

The road to Jalalabad is open at the moment though travelers would be well advised to consult UNHCR before hand and get approval from the regional commanders. Transporting freight is generally okay though again the commanders would need to be informed before traveling and an armed escort taken.

3.6 Mines
With 22 square kilometers of mined areas, Kabul must be considered very dangerous. A 1995 survey mapped the mined areas and these are well documented by Demining. Small scale maps of mined areas are available for NGOs. The regional manager of UN Demining in Kabul is Tahsin Disbudak who will put on a mine awareness course for newly arriving expatriates.

D.4 POTENTIAL LOGISTICS / REHABILITATION PROJECTS:

Rehabilitation of health facilities is not a key issue in this city despite the destruction. If a facility is destroyed then it is likely that the surrounding area is also destroyed and the people have left thus
negating the need to rehabilitate the facility. Most of the health facilities are either intact or else need re-building from rubble. Most facilities do not have glass in the windows though to provide glass in Kabul is to paint the Tay Bridge: a never ending task. (Though a good business if you are selling!)

E. CONCLUSIONS

1. The general feeling among the NGOs and the MoPH is that there are already too many health NGO's in Kabul and the work is covered. No one spoken to could identify a clear gap in the provision of health services in the city. Certainly it would be hard for MERLIN to justify a programme in the same terms as MERLIN justified its programmes in Kandahar and Farah. With so many international NGOs and other agencies working in 200+ health facilities in Kabul province it is easy to say that Kabul as a whole is covered.

2. However despite of good global coverage, there exist location specific gaps in the current provision of services. Many of these gaps though are in preventative health care or else too disparate in scope which, should MERLIN intervene, would result in a hoch poch programme filling gaps in a variety of geographical and sectoral areas. Even where geographical and sectoral gaps exist that a new programme could fill, it would not be accurate to say that access to health care is in any way diminished. Kabul is a relatively condensed city with a good number of health care facilities city wide. Transport is sufficiently good and walking distances sufficiently short that travelling time to the nearest primary health care facility is probably not more than 20 minutes within the city and 60 minutes to the nearest hospital. In these terms is it very hard to justify a new project here where access is so good.

3. ICRC and MSF(France) have surgical emergency preparedness capacities. MSF has medical capacities to cope with a measles and cholera epidemic. Other NGO could respond rapidly given the initial push from one of the key players. The health data at present indicates no abnormally high incidence of morbidity or mortality. The problem with responding to any epidemic is simply getting reliable data in time to respond.

4. There is no work that Merlin could do that another good NGO could not do. Given the high logistical cost of setting up a programme it would better for an NGOs already here simply to expand operations. This however is unlikely to happen and in the meantime it may be useful for Merlin to establish a programme for other longer term agencies to take over. With a Kabul programme Merlin could also support the MoPH and ACBAR in coordinating the health services provided in the city. This perhaps would be as useful (if not more so) as any medical programme. Coordination however is not in MERLIN's mandate.

5. Kabul is suffering a chronic emergency which short term programmes and funding will not necessarily help resolve. Kabul, like the rest of the country, needs emergency programmes that can grow into longer term development projects over a period of years.

F. RECOMMENDATIONS

1. At present there is no reason to justify a MERLIN intervention in Kabul. There are enough other agencies to cover present health needs. MERLIN however should closely monitor the situation in Kabul examining in particular:
   a) basic health and nutrition data for deteriorating health and nutritional status of the population.
   b) the continuing operations of NGOs and of AVICEN in particular for sudden gaps in the provision of services and planned agency activities.
   c) the security situation for potentially large numbers of returning refugees and movements of internally displaced people within the city.
   d) other unforeseen circumstances

2. However, MERLIN should seriously consider opening an administrative and liaison office in Kabul as part of its Badakshan programme should that get off the ground. Such an office would
be very useful for coordinating MERLIN's operations in Afghanistan as well as liaising with other agencies in Kabul and Peshawar. The office could also play a key role in coordinating health services in Kabul.

3. MERLIN should re-evaluate in three months time.

Thanks and Apologies

Ross Everson of ACBAR was instrumental in facilitating this evaluation and pulled out all the stops for us. Many thanks also to SCA for their hospitality in Kabul and IRC for the use of their Land Cruiser. Many others offered hospitality, help, advice and hot showers. Thanks to them also.

Thanks to all who proffered information and advise. Apologies to those whose information and advice we have misinterpreted, misrepresented, misanalysed and ignored. Like any document evaluations too can contain failings.