

AIDS



IN  
SEARCH  
OF  
FULFILMENT

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96

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98

THREE YEARS OF  
ACHIEVEMENTS

**I N S E A R C H O F F U L F I L M E N T**

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A SPECIAL ISSUE ABOUT  
THREE YEARS OF ACHIEVEMENTS  
1996 1997 1998

BY  
**AFGHAN HEALTH & DEVELOPMENT SERVICES**  
( AHDS )

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# CONTENTS



• PREFACE	1
• INTRODUCTION	2
• BASIC INDICATORS IN THE COUNTRY	3
• AHDS' BACKGROUND	5
AHDS TARGET AREAS	6
AHDS' GOALS	7
CURRENT PROJECT SITES	7
PHC STRUCTURE	7
CO-ORDINATION WITH OTHER AID ORGANIZATIONS	7
FINANCE	7
ADMINISTRATION	7
MONITORING AND SUPERVISION	7
• COMMUNITY INVOLVEMENT	8
• ACHIEVEMENTS	9
CONSTRUCTED/REHABILITATED PROVIDED PHC SERVICES	9 10
DEVELOPMENT OF HUMAN RESOURCES	13
COMMUNITY CONTRIBUTION	14
• AFGHANISTAN'S REGIONAL HEALTH SYSTEM	15
• PARTNERSHIP AND COORDINATION	16
ADA	16
MSF-HOLLAND	16
HNI	16
MOPH	16
UNICEF	16
WHO	17
• CONCLUSION	18
• ABBREVIATIONS & ACRONYMS	19
• AHDS' ORGANIZATIONAL STRUCTURE	

# PREFACE



## REMARKS FROM THE DIRECTOR

Political instability, fresh fighting in certain parts of Afghanistan, economical abnormalities and social exceptions have never diminished the desire for peace that most Afghans share.

Time after time this very desire has been violated, derailed, and betrayed by certain individuals or groups involved in the conflict. Yet there are still those who try to provide hope through aid, rehabilitation and development.

AHDS is proud to be one of those who try to better the situation of Afghans. In the past decade it has worked in the field of health and development and takes pride in its accomplishments. This three years report covers the significant contributions of AHDS in southwest Afghanistan.

It should be noted that AHDS is one of the major Primary Health Care providers in its region. It has taken an active role in the rehabilitation and development of the health infrastructure. AHDS' integrated Community Based Primary Health Care Program in the southwest, provided health care to the vulnerable group: mothers and children. It has created equal employment opportunities for men and women and has enhanced the capacity of local staff through its training programs.

I would wish to acknowledge the fact that without the dedication, honesty and hard work of the AHDS staff and the monetary support of its donors AHDS' accomplishments would never have been realized.

I hope that AHDS can continue to provide necessary health and development for the needy people of Afghanistan.

*Aziz R. Qarghah*

**Aziz R. QARGHAH**  
AHDS Director

# INTRODUCTION

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**A**fghanistan has been among the least developed countries in Asia for many years. The political, social and economical infrastructures are severely damaged. The prolonged state of war, during the past 19 years has interrupted most initiatives for progress and worsened the general situation. Land is diverted or not usable due to mines. Fighting is on going in many parts of the country. This instability has displaced very large numbers of people to various provinces of Afghanistan. In 1996, Afghanistan placed 169th out of 175 countries in the International Human Development Index (HDI) ranking.

**A**mong the worst affected social areas, the health sector has suffered for the duration of the unrest. More than 70% of the domain relies on outside assistance. Only 26% of the population receive treatment for common injuries and diseases. Afghanistan has one of the highest infant, child and maternal mortality rates in the world. Until the seventies, there was a distinct geographic distribution of certain diseases such as leprosy in certain parts and malaria in others. Rapid and continued population movements have caused major changes in the geographic distribution of diseases, affecting the morbidity and mortality patterns of the communities. Many communicable diseases are spreading due to this migration as well as the consequent overcrowding of households, poor environmental sanitation, and malnutrition.



# BASIC INDICATORS

# IN THE COUNTRY

## POPULATION

The 1998 population of the country was estimated at 21,149,479. 45% of this number consists of children under 5 and women of childbearing age.

## TOTAL FERTILITY

In a three-province survey in the 1970s, it was found that women over 45 had an average of nine children of whom six were still living. Of the offspring's who died, 43% died before age one, 29% between one and two, 16% between two and three years old, and 12 % between three and five years old.

## LIFE EXPECTANCY

Overall life expectancy in Afghanistan, 33 years of age in 1960, had risen to 45 in 1995<sup>1</sup>. Women's life expectancy is 43 years, the lowest in the world.

## GROWTH RATE

Afghanistan's annual fertility and growth rates are twice those of the average for other developing countries. Despite high mortality among key segments of the population and low life expectancy, the population grows fast. The annual growth rate ranges between 2.6% in rural and 3.1% in urban areas<sup>2</sup>. On average, 1,000,000 children are born in Afghanistan every year.

## MORTALITY

Infant and under-five mortality rates are at 165 and 257 per 1000 live births since 1995. The maternal mortality rate has more than doubled, from 640 per 100,000 live births in 1990, to 1700 per 100,000 in 1996<sup>3</sup>. One reason for these high rates is likely the economic collapse and consequent pressures on maternal and child nutrition. Other reasons include deterioration of

access to safe water and sanitation, destruction of urban health services, and insufficient funding for the rural health network.

## EDUCATION

Afghanistan has lost its educational structures and professionals during the two decades civil war. Existing data on education indicates gaps in the qualitative as well as quantitative nature of education. The system of education has suffered heavy damage due to absence of a commonly accepted curriculum, evaluation processes and loss of professionals. In addition the problem of education is resulted from some policies of local authorities on gender issues, lack of qualified teachers, inadequate remuneration as well as lack of equipment and teaching materials.

## PEACE & DEVELOPMENT

For a country in such dire straits, it is an enormous task to develop into a place where the standard of living approaches normalcy. Afghanistan desperately needs to be given the chance to start on the road to recovery. This will require co-operation and determination, time, energy, and monetary support, among other things. The vicious circle, unfortunately, is that for there to be development, there must be peace; for peace, Afghanistan needs more development. AHDS, devoting their time and energies to the country, need help to break the vicious circle of neediness and instability.

During these 19 years of crisis, almost all of the functioning hospitals, clinics, and basic health facilities have been totally or partially destroyed.

<sup>1</sup> UNICEF 1997

<sup>2</sup> UNICEF 1999

<sup>3</sup> UNICEF & WHO 1996

<sup>4</sup> UNICEF 1997, WHO 1996

There is also a lack of guidelines, regulations and supervision in relation to the functioning of the health facilities, since these infrastructures have virtually disappeared. Lastly, and very importantly, female health workers are in extremely short supply. This is because of the absence of educated people, especially women, in the country, as well as the lack of training and opportunities. As a consequence, practical access to the health facilities, especially for women, has become seriously limited.

All of these constraints, practical and physical, have resulted in an urban-based, poor health system. Large parts of the rural areas are deprived of good care, especially in those areas where the population is poor and opportunities for private practice are limited. Due to the virtual absence of government-run health services, much of the population depends on services offered by NGO's, such as Afghan Health and Development Services (AHDS).

## YOUR SMALL CONTRIBUTION THROUGH AHDS' PRIMARY HEALTH CARE PROGRAM MAY SAVE THE LIFE OF AN AFGHAN WOMAN OR CHILD



# AHDS BACKGROUND

**A**fghan Health and Development Services (AHDS) is a non-profit, non-governmental, non-political organisation founded by Afghans with expertise and training in the fields of health, education, and development. Since its establishment in April 1990, AHDS has been involved in the rehabilitation of Afghanistan's health sector and the provision of comprehensive primary health care services to the needy people of Afghanistan.

**T**he organisation has developed considerably in the past nine years, having grown from operating eight health facilities with 30 staff in 1990/91, to running 38 health facilities (of various categories) with over 250 staff members in 1998. AHDS has a proven record in building

and administering health facilities in different locations in Afghanistan. AHDS has so far established 56\* health facilities including a Regional Health Training Centre (RHTC) in the following provinces: Logar, Nangarhar, Wardak, Kandahar and Urozgan.

**F**or the past three years, AHDS has dedicated itself mainly to the rehabilitation of ruined health facilities and the construction of new ones, as well as the provision of primary health care services through these facilities in the south-west provinces of Kandahar and Urozgan. It has supplied health services at the district, sub-district, and village levels.

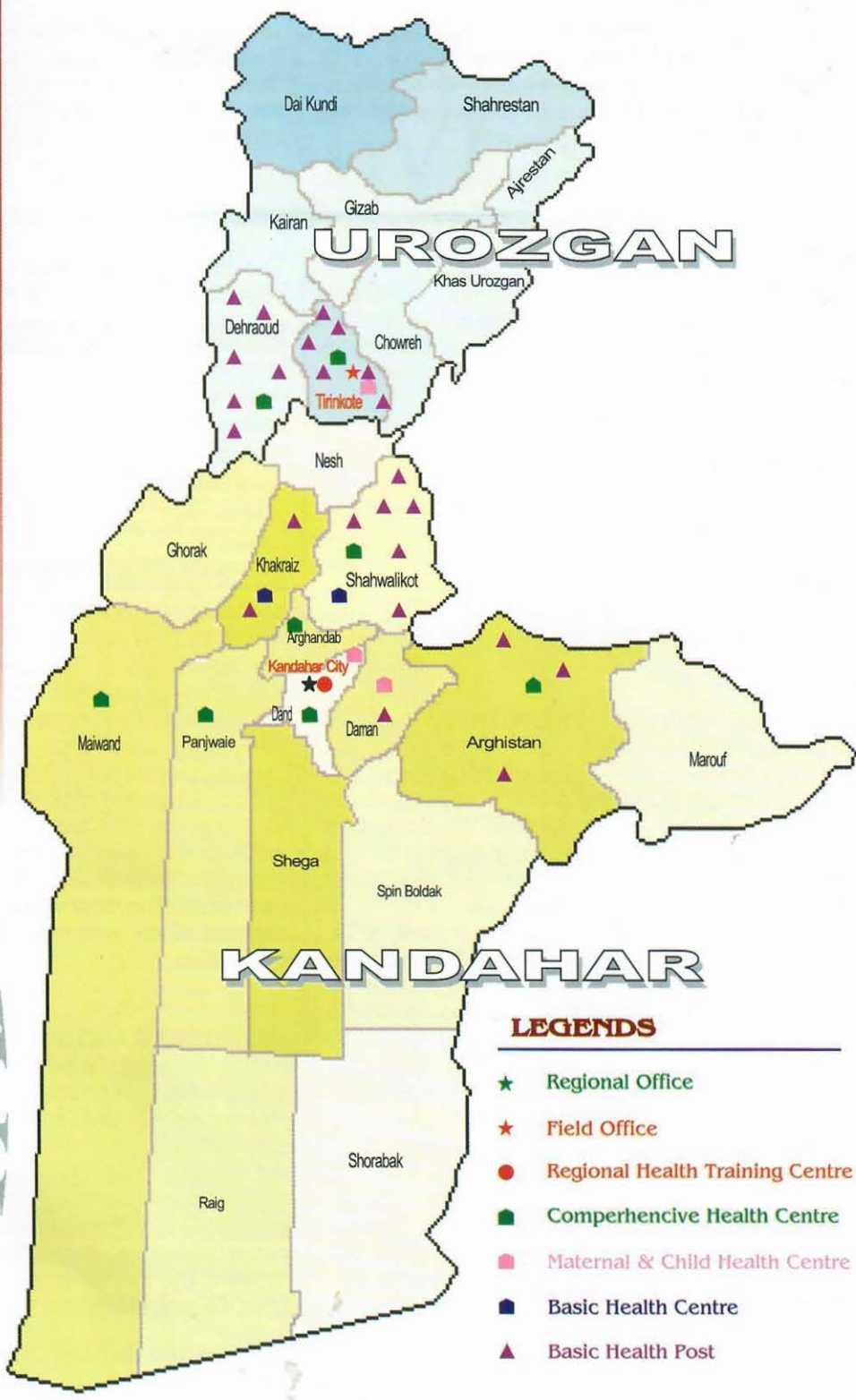


*AHDS' staff welcomes new challenges*

\* 38 of these facilities (including the RHTC) are ongoing; the rest have been successfully handed over to the local authorities.



# AHDS TARGET AREAS



## AHDS GOALS

AHDS' primary goals are to participate in the rehabilitation of Afghanistan's health care system and provide health and development services to meet the current and future needs of the Afghans living in and returning to Afghanistan.

The overall objective of AHDS Integrated Primary Health Care Program is to reduce morbidity and mortality rates with special focus on mother and child and to promote health through cost effective, affordable primary health care interventions.

### CURRENT PROJECT SITES

#### Kandahar Province

Kandahar City, Arghandab, Arghistan, Dand, Daman, Khakrez, Maywand, Shahwalikote and Panjwaie districts.

#### Urozgan Province

Tirinkote and Dehrawoud districts.

### AHDS PHC STRUCTURE

9 MCH/CHC's in 9 district's centres  
2 MCH centres in 2 province's centres  
2 BCHs in 2 highly populated areas  
24 BHPs in 24 accessible villages  
1 Regional Health Training Centre

### AHDS COORDINATION WITH OTHER AID ORGANIZATIONS

AHDS strongly believes in the coordination among NGOs and UN agencies and, in order to act as advocate for the needy people of Southwest Afghanistan, has been trying hard to build on and take advantage of its relations with other organizations working in the region. AHDS has had close contact and meetings with MSF, ADA, UNICEF, WHO, CHA, MOPH and HNI to exchange ideas, share experiences and information, and coordinate activities. AHDS has taken the initiative to motivate other organisations to hold internal NGO meetings on a regular basis. We are presently partners in various projects with MSF-Holland, UNICEF, ADA and HNI.

### AHDS FINANCES

Continuous efforts are made by AHDS' finance department in Peshawar to keep all the financial aspects of the project transparent, up to date, and in accord with the donors' format and standards. There are regular visits of the Finance Director to the project site to evaluate financial affairs of the project. AHDS' financial affairs are subject to annual audits.

The following table is an overview of the three years financial status of the organisation.

Funding agency	YEARS 1996-1997-1998
European Union	US\$ 990,000
MSF-Holland	US\$ 385,000
UNICEF	US\$ 105,000
UNHCR	US\$ 23,000
Help Germany	US\$ 5,000
Community	US\$ 30,000
Others	US\$ 1,000
<b>Total</b>	<b>US\$ 1,539,000</b>

### AHDS ADMINISTRATION

Administration activities are exercised both from the main office in Peshawar, the regional office, Kandahar City, and the field office, Urozgan, within the prescribed authorities vested in them. Policies have been developed by the main office and executed by the field offices. AHDS' main office as the main decision making body has been in touch with donors and other concerned agencies to facilitate the means for smooth operation of the projects. Overall supervision of the projects has been one of the most serious responsibilities of the regional office, with regular consultation with the main office.

### MONITORING AND SUPERVISION

AHDS hopes to meet all the challenges of a sustainable, co-ordinated, and effective PHC Program of implementation and impact assessment. A continuous monitoring and supervision system could achieve this. Therefore, to improve and maintain the quality of our services, AHDS has attempted to bring about a comprehensive monitoring and supervision system by involving partners such as ADA, UNICEF, and MSF.



# COMMUNITY INVOLVEMENT

One of the most important issues in the implementation process of Primary Health Care is that the community should take part in the process. The residents and authorities need to realise the importance of being healthy; they should be encouraged to actively participate in meeting their health needs; they need to know how to prevent disease and promote health; finally, they should have some "ownership" of the enterprise.

Establishing Community Health committees, therefore, in the target areas, was of major concern. So was the implementation of the Cost Recovery Program.

AHDS was the first to introduce such a scheme in the region. We are pleased to report that it is working, but it is only a beginning. We hope it will reflect positively on and inspire more appreciation for the quality of health service delivered.



The community and local authority's support and trust enable AHDS to fulfil its essential objective, providing Primary Health Care services to the vulnerable group: mothers and children.



# ACHIEVEMENTS

**D**uring the last three years (1996 to 1998), AHDS has been responsible for the establishment of an extensive PHC network in the rural areas of the Kandahar and Urozgan provinces. In order to increase maternal and child access to health services, we have built or rehabilitated various health care facilities. We have also used our Regional Health Training Centre to provide initial training courses or refresher courses, along with seminars and workshops, to health workers and community members in the fields of health and health awareness.

## CONSTRUCTED / REHABILITATED

Through the rehabilitation of existing buildings and the establishment of new facilities, AHDS increased the access to health services for the population in general, and for mothers and children in particular. These facilities are rehabilitated/constructed, equipped, staffed and inaugurated:

- Shahwalikote CHC, 16 rooms, in October 1995\*.
- Deh Khwaja MCH, 6 rooms, in Sep.1995\*.
- Shahwalikote BHC, 6 rooms, in March 1996.
- Daman BHC, 6 rooms, in March 1996.
- Khakrez BHC 6 rooms in April 1996.
- Arghistan MCH/CHC 22 rooms in August 1996.
- Deh Rawood MCH/CHC, 22 rooms, in 1996.
- Tirinkote MCH/CHC, 30 rooms, in 1996.
- Female staff hostel, Shahwalikote MCH, in 1998.
- Arghandab MCH/CHC, 22 rooms, in August 1998.
- Tirinkote MCH, 9 rooms, in September 1998.
- Maywand MCH/CHC, 16 rooms, in



*Building of Tarinkowt Maternal and Child Health Centre (MCH)*

\* These facilities are still operational, hence they are mentioned here.

	Year 1996	Year 1997	Year 1998	Grand total
<b>Promotive &amp; Preventive services</b>				
Health Education	169,595	239,259	218,036	626,890
Nutrition	21,321	12,500	8,816	42,637
Immunization	42,172	177,267	132,525	351,964
Children	34,623	144,901	102,624	282,148
Women	7,549	32,366	29,901	69,816
<b>Curative services</b>				
Total treated	96,232	119,275	209,113	424,620
Maternal health care	11,369	11,307	13,665	36,341
Children (< 5 years age)	32,285	54,658	53,006	139,949
Other (M & F of >5 years age)	52,578	53,310	142,442	248,330
<b>Total services</b>	<b>329,320</b>	<b>548,301</b>	<b>568,490</b>	<b>1,446,111</b>

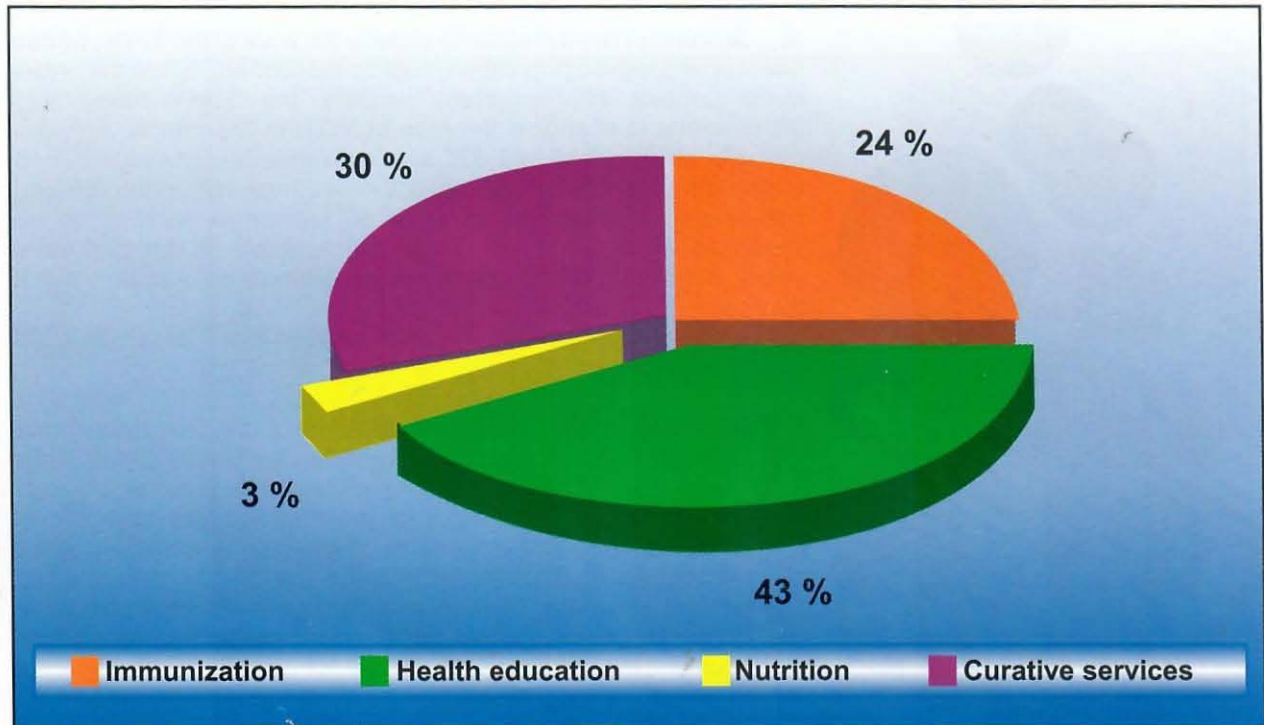
*AHDS Health activities from 1996 to 1998*

### PROVIDED PRIMARY HEALTH CARE SERVICES

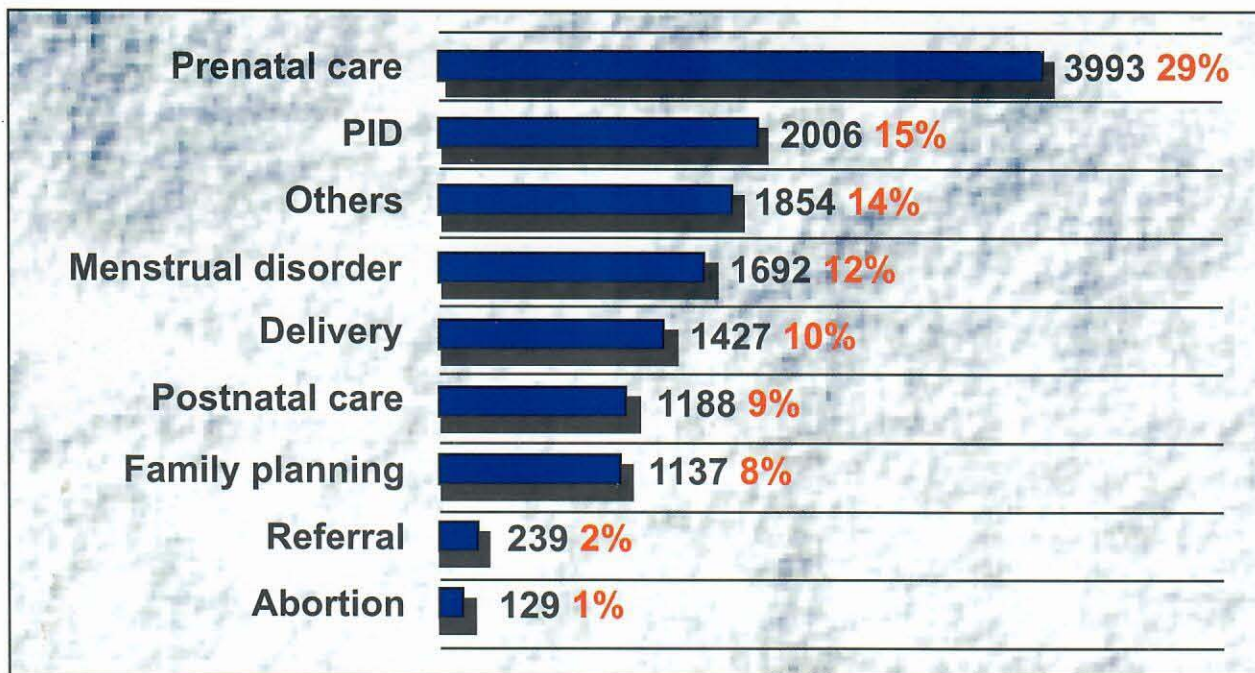
**Promotional and Preventive Services:**

The major part of AHDS activities is dedicated to promotive/preventive health services, which makes 70% of total services offered during the

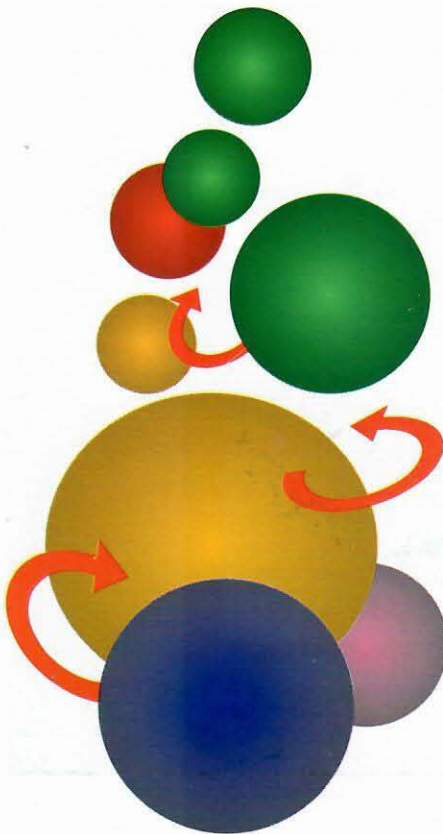
reporting period (health education 43%, Immunization 24% and nutrition 3%), while curative services accounts for 30% of the total (1,446,111).



*Percentage of different types of health services offered by AHDS facilities (1996 - 1998)*



*Different types of maternal health service, from AHDS activities during the year 1998*



AHDS strongly believes in preventive interventions and promotional measures to maintain and support the people's health. These measures include the work of the TBAs, whose effect on the female population must be mentioned. Since they have direct contact with so many women, the TBA's have been instrumental in changing the face of MCH in the region. We are proud to claim a total of 1,335 safe deliveries by our trained TBAs during the year 1998. They have instilled trust in the network and encouraged the target population to support a number of the strategies we feel are vital to the communities. In the past three years, AHDS has offered the following promotional and preventive services:

Health Education, Nutrition and Immunisation to a total of 1,236,998 women and children.

The data related to maternal health care during year 1998 shows that pre-natal care accounts for 29%, delivery 10%, post-natal care 9%, PID 15%, family planning 8%, referral 2% and abortion 1% of the total services provided for this category of population. The rest (14%) are other obstetric/gynaecological cases of less importance. It is obvious from the graph that preventive and promotive care such as pre-natal care, family planning and post-natal care account for the majority of the attendance, which is indicative for the population awareness about importance of these services.



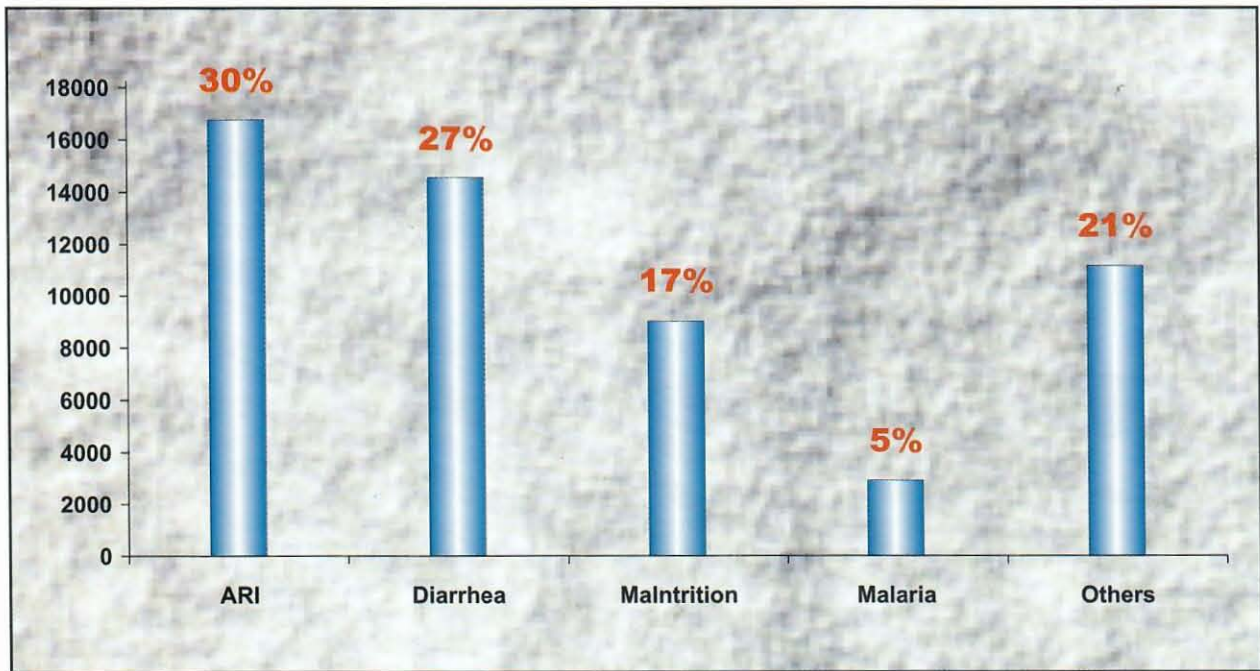
*Health education seminars for female health educators from AHDS' health facilities*

**Curative Services:**

One of the major components of PHC, is the treatment of common ailments. Over the last three years, curative services have been offered to the

following:

Mothers, children <5 years and other (male and female >5 years) 424,620 people.



*Percentage of top four diseases prevalent among less than 5 years*

Looking at the data from AHDS health activities during the year 1998, ARI accounts for 30% and Diarrheal diseases for 27% of all diagnosis in children less than five years old, this is followed by malnutrition (17%) and malaria (5%).

All planning requires focus on these diseases, as they are the main causes of morbidity and probably mortality in this age group in the target area.



*AHDS' qualified female health service providers are taking care of pregnant mothers*

## DEVELOPMENT OF HUMAN RESOURCES

Developing local human resources is essential for the implementation of a sustainable system of PHC. The technical instruction, as well as guidance with areas such as policy issues, management, and strategies such as cost

recovery, serve to strengthen the local authorities and better prepare them to take over the PHC responsibilities in the future. In order to enhance the local health providers' strengths, AHDS has given the following training:

### FEMALE HEALTH WORKERS 543

- 12 MLHW's, refresher course
- 520 Traditional Birth Attendants (TBA's), initial course
- 3 Vaccinators trained and deployed
- 8 MLHW's, refresher course



## MALE HEALTH WORKERS

791

- 109 Basic Health Workers (BHWs), initial course\*
- 235 BHWs, refresher course
- 32 Vaccinators, initial course
- 17 Vaccinators' refresher course
- 66 Mid-Level Health Workers (MLHWs), refresher course
- 48 MLHWs, ARI seminar
- 36 various health workers and medical doctors, primary health care seminar
- WHO publication translated into Dari and insertion of extra English class in BHW initial course.
- 2 Dental Technicians, initial course [conducted by WHO/RADA]
- 35 participants, ARI seminar
- 30 participants, malaria seminar
- 14 participants, nutrition/malnutrition seminar
- 66 participants, CDD/cholera seminar
- 31 participants, EPI-plus seminar
- 28 participants, management workshop
- 42 participants, CDC workshop
- All staff of AHDS undergoes continuous on-the-job training and updating.

\* NGOs had found some BHW's performance to be unsatisfactory, and supervision of the BHP's presented difficulties. Therefore, BHW Initial Courses were henceforth suspended.

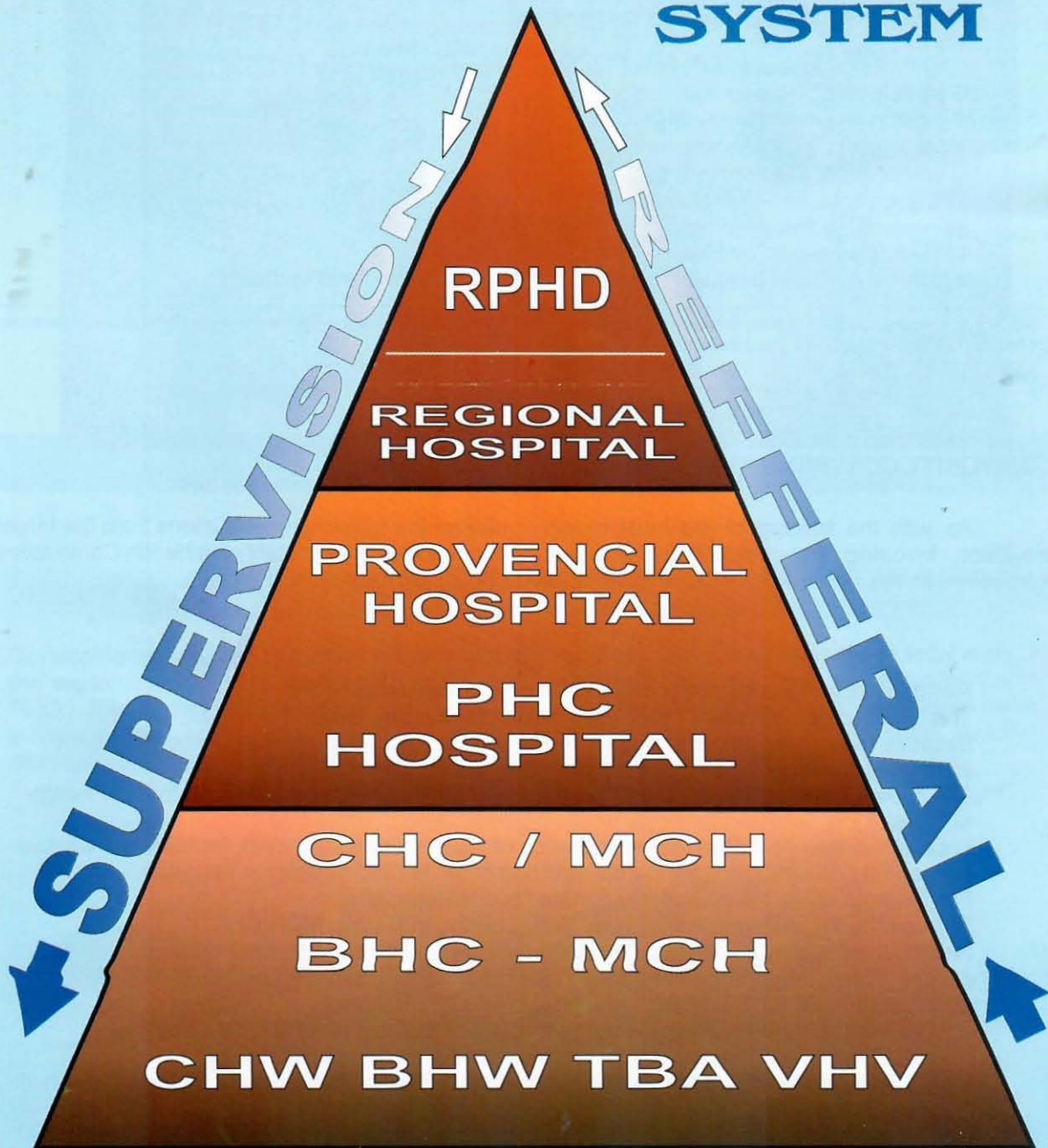
## COMMUNITY CONTRIBUTION

As with the training of the local health providers, involving the residents/beneficiaries themselves in the network is vital. AHDS has

elicited the following contributions from the target communities, most notably the Health Committees and the Cost Recovery Program:

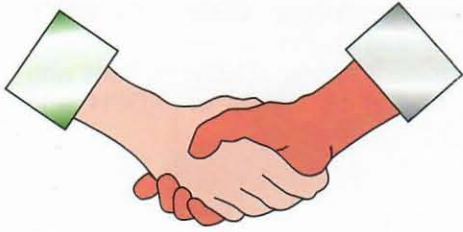
- Residents of the target areas provided 28 rooms to be used as BHPs.
- The communities donated three pieces of land for building BHCs.
- Because of local conflict, Shorandam BHP had to be moved to another village. Villagers volunteered to build a new room to house the new facility.
- The communities of Daman, Dand, Khakrez and Shahwalikote donated land for their health facilities.
- Local authorities permitted the rehabilitation of the governmental health facilities and allotted one jeered (2000m<sup>2</sup>) land for the construction of MCH/CHC facilities in Panjwaie.
- For Tirinkote MCH, the community donated two jereeb land.
- The community pays rent for the male OPD building in Daman MCH/CHC.
- Health Committees: 23 health committees were established in different highly populated villages. These health committees have monthly meetings with the participation of AHDS technical staff. So far, they have:
  - Helped in paving the way for agreement of the community for TBA training.
  - Encouraged the community to vaccinate the mothers and children.
  - Encouraged the community to participate in making decisions for their own health.
  - Encouraged people to contribute to their own health cost.
- Cost Recovery Program: AHDS persuaded the beneficiaries of their facilities to share partial costs of the services. The community contribution toward their health costs was remarkable. Around 828 million Afghanis were contributed during the reporting period.

# AFGHANISTAN REGIONAL HEALTH SYSTEM



AHDS CONTRIBUTES TO THE REHABILITATION OF HEALTH INFRASTRUCTURE, PROMOTES COMMUNITY HEALTH AND PROVIDES HEALTH SERVICES.

# PARTNERSHIP AND CO-ORDINATION WITH OHTER



## AID AGENCIES

### ADA

AHDS' Integrated PHC Program started in 1994, working closely with ADA. ADA co-signed the project, which the European Union funded. The two agencies have had a direct working relationship throughout the implementation of the project and our co-operation and sharing of information still continues.

### MSF-Holland

In late 1995, AHDS and MSF entered into a contractual agreement to provide PHC services in Urozgan with the special focus on mother and child health care services. AHDS' male/female doctors, nurses and midwives acted as MSF counterparts in the implementation of the project. TBA training, a very sensitive project, was successfully accomplished in the target areas.

In 1997, the management of the entire project was delegated to the AHDS management team. MSF's role changed from implementation partner to supervisor/consultant.

Of course, the financial assistance of MSF made it possible to achieve the set objectives. This co-operation and monetary commitment still continues.

### HNI

Based on a mutual agreement, HNI integrated its Malaria Control Program into AHDS' PHC network. Both agencies are optimistic about continued collaboration in the future.

### MOPH

Throughout the years, AHDS has succeeded in establishing a cordial working relationship with the MOPH authorities in the target areas. AHDS has, with its long-term policies of handing over the facilities to the MOPH, assisted the MOPH personnel and enhanced their technical capabilities. AHDS is certain that the present technical staff will play a vital role in the future health set-up of the country.

### UNICEF

AHDS and UNICEF, based on a Memorandum of Understanding (MOU) and mutual agreement, are co-operating in the implementation of the PHC Program. UNICEF provides technical assistance and guidance, EPI equipment and supplies, essential drugs for MCH centres, and financial support.



## WHO

- WHO provided technical assistance to AHDS.
- WHO integrated Tuberculosis Control program in Shahwalikote MCH/CHC, also they provided microscopes for other AHDS MCH/CHCs to screen for TB causative microorganism.
- Seminars, workshops and training courses conducted jointly with WHO, UNICEF and MOPH.
- Assessment survey of MCH facilities with co-operation of WHO, as MOPH and UNICEF.

AHDS would like to take this opportunity to acknowledge with gratitude the monetary contribution and technical assistance of those, who made AHDS' dream to become a reality.



*United Nations Children Fund*  
UNICEF



*European Union*  
EU



*United Nations High Commission for Refugees*  
UNHCR

**HELP** HELP



*World Health Organization*  
WHO



*Medicins Sans Frontiers*  
MSF

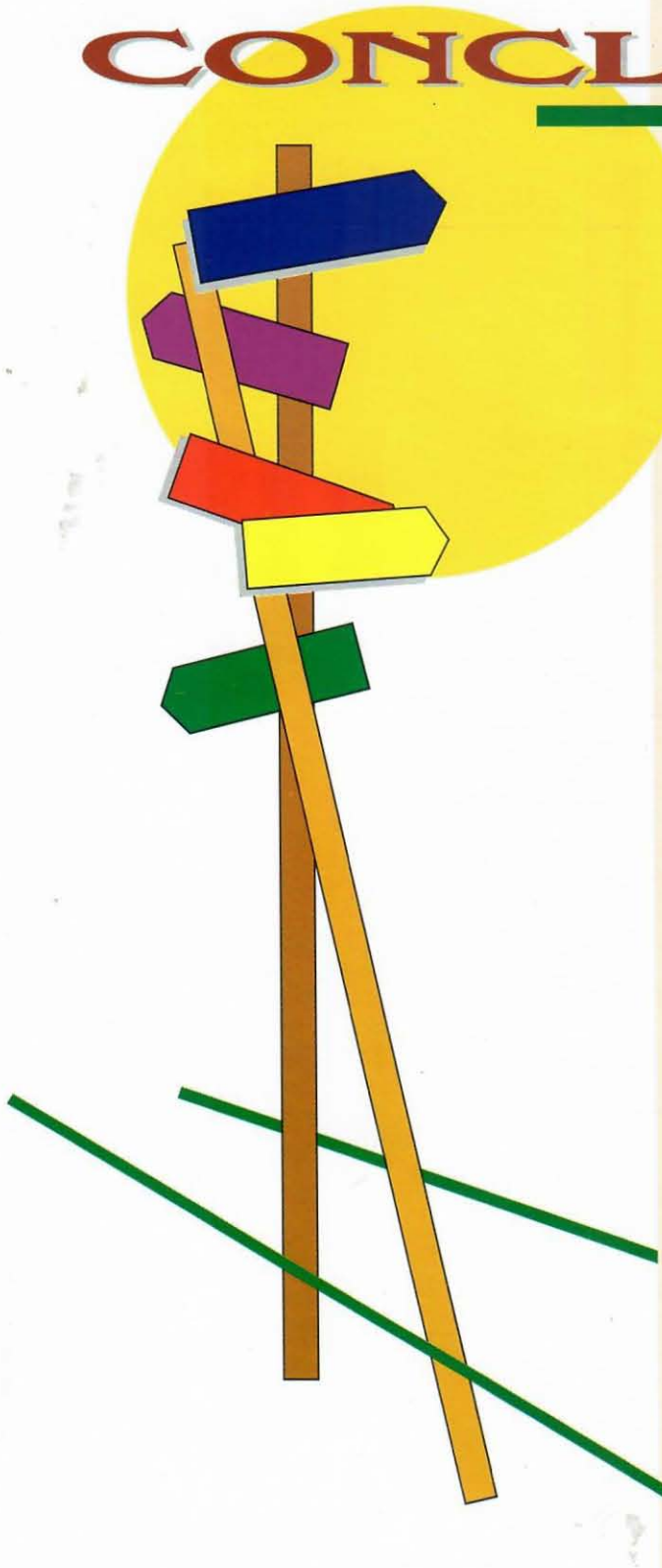


*Afghan Development Association*  
ADA



*Health Net International*  
HNI

# CONCLUSION



AHDS takes pride in the fact that, after almost two decades of war, we have been instrumental in re-establishing health services in the target areas. The impact of our rehabilitation can clearly be seen in the increased numbers of people served in the last three years, especially women and children. As a result of our implementing promotional and preventative health services, such as EPI, TBA training, nutrition and health education, the overall health status of the people has improved.

Offering different types of training to the health providers, AHDS is contributing a great deal to the Human Resource Development of Afghanistan's future health sector. Our effort to involve the concerned communities is also a significant step towards the goal of an independent health care network.

In search of fulfilment, AHDS has learned that integrated community based primary health care is the most reliable, practical and acceptable path in reaching the "health for all" strategy in Afghanistan. Commitment of the communities to contribute in their health program, training and application of female health workers like TBA and extension of the health project to remote villages was a very fascinating yield. Broadening the spectrum of such integrated approach has valuable impact on the health of communities.

AHDS' Primary Health Care Program is vital to the well being of the people of Kandahar and Urozgan; even with all the strides taken, now is too early to pull our support and services out. To make them self-sufficient in their health care, the program needs to continue. Only with hope and assistance from other sources is this possible.

## ABBREVIATIONS AND ACRONYMS

### HEALTH TERMINOLOGY:

ARI	Acute Respiratory Infection
BHC	Basic Health Center
BHP	Basic Health Post
BHW	Basic Health Worker
CHW	Community Health Worker
CDC	Communicable Disease Control
CDD	Control of Diarrheal Diseases
CHC	Comprehensive Health Center
EPI	Expanded Program of Immunization
EPI-plus	EPI and other common communicable diseases
MCH	Maternal and Child Health
MLHW	Mid-Level Health Worker
PHC	Primary Health Care
RHTC	Regional Health Training Center
RPHD	Regional Provincial Health Department
TBA	Traditional Birth Attendant
VHV	Village Health Volunteers

### AID ORGANISATIONS:

AVICEN	Afghan Vaccination/Immunization Center
ADA	Afghan Development Association
CHA	Co-ordination for Humanitarian Assistance
HI	Handicap International
HNI	Health Net International
IAHC	Islamic Aid Health Center
ICRC	International Committee of the Red Cross
IPH	Institute of Public Health
MOPH	Ministry of Public Health
MSF	Medicins Sans Frontieres
RADA	Rural Agency for Development of Afghanistan
SWABAC	Southwest Afghanistan and Baluchistan Association for Co-ordination
UN	United Nations
UNDP	United Nations Development Program
UNHCR	United Nations High Commission for Refugees
UNICEF	United Nations Children's Fund
UNICHA	United Nations Internal Coordination of Humanitarian Aid
WFP	World Food Program
WHO	World Health Organization



Afghanistan desperately needs to be given the chance to start on the road to recovery. This will require co-operation and determination, time, energy, and monetary support, among other things. The vicious circle, unfortunately, is that for there to be development, there must be peace; for peace, Afghanistan needs more development. AHDS, devoting their time and energy to the country, needs help to break the vicious circle of neediness and instability. On this auspicious temper, AHDS enters into its 10th year of activities as a philanthropist, non-profit, and non-governmental organization.



For the past three years AHDS has dedicated itself to the rehabilitation of the ruined health facilities and the construction of new ones. It has extended health services to the district, sub-district, and village levels. AHDS has been restoring the ruined health facilities occupied by armed people and inviting the Afghans to work for peaceful healthy lives. Developing human resources along with the implementation of the projects increases the manpower of the local communities in the long run. AHDS has taken part in this exercise to provide opportunity for positive changes. AHDS as a charity organization, would greatly appreciate any assistance to enhance the provisions of such services to the destitute and the needy.

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Afghanistan.

**Account Number:**

PK RS:  
01-010-0489-7  
US \$:  
576-2  
Mashreq Bank,  
14 Sadar Road,  
Peshawar Cantt, Pakistan.