THREE YEARS OF

IN SEARCH OF

FULFILMENT

1996
1997
1998

THREE YEARS OF

ACHIEVEMENTS
IN SEARCH OF FULFILMENT

A SPECIAL ISSUE ABOUT
THREE YEARS OF ACHIEVEMENTS
BY
AFGHAN HEALTH & DEVELOPMENT SERVICES
( AHDS )

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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
AHDS Director
Afghanistan 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.

Among 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 25% 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.
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. 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. 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 840 per 100,000 live births in 1990, to 1700 per 100,000 in 1996. 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 cooperation 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.

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1 UNICEF 1997
2 UNICEF 1999
3 UNICEF & WHO 1996
4 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).
Afghan 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.

The 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.

For 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.

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AHDS' staff welcomes new challenges

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

- Regional Office
- Field Office
- Regional Health Training Centre
- Comprehensive Health Centre
- Maternal & Child Health Centre
- Basic Health Centre
- Basic Health Post
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 Panjwai districts.
Urozgan Province
Trinkote 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 co-ordinate 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.

<table>
<thead>
<tr>
<th>Funding agency</th>
<th>YEARS 1996-1997-1998</th>
</tr>
</thead>
<tbody>
<tr>
<td>European Union</td>
<td>US$ 990,000</td>
</tr>
<tr>
<td>MSF-Holland</td>
<td>US$ 385,000</td>
</tr>
<tr>
<td>UNICEF</td>
<td>US$ 105,000</td>
</tr>
<tr>
<td>UNHCR</td>
<td>US$ 23,000</td>
</tr>
<tr>
<td>Help Germany</td>
<td>US$ 5,000</td>
</tr>
<tr>
<td>Community</td>
<td>US$ 30,000</td>
</tr>
<tr>
<td>Others</td>
<td>US$ 1,000</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>US$ 1,539,000</strong></td>
</tr>
</tbody>
</table>

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.
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.

A HDS 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

During 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.
- Tirinkote MCH, 9 rooms, in September 1998.
- Maywand MCH/CHC, 16 rooms, in

* These facilities are still operational, hence they are mentioned here.
AHDS Health activities from 1996 to 1998

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).

<table>
<thead>
<tr>
<th>Promotive &amp; Preventive services</th>
<th>Year 1996</th>
<th>Year 1997</th>
<th>Year 1998</th>
<th>Grand total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Education</td>
<td>169,595</td>
<td>239,259</td>
<td>218,036</td>
<td>626,890</td>
</tr>
<tr>
<td>Nutrition</td>
<td>21,321</td>
<td>12,500</td>
<td>8,816</td>
<td>42,637</td>
</tr>
<tr>
<td>Immunization</td>
<td>42,172</td>
<td>177,267</td>
<td>132,525</td>
<td>351,964</td>
</tr>
<tr>
<td>Children</td>
<td>34,623</td>
<td>144,901</td>
<td>102,624</td>
<td>282,148</td>
</tr>
<tr>
<td>Women</td>
<td>7,549</td>
<td>32,366</td>
<td>29,901</td>
<td>69,816</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Curative services</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Total treated</td>
<td>96,232</td>
<td>119,275</td>
<td>209,113</td>
<td>424,620</td>
</tr>
<tr>
<td>Maternal health care</td>
<td>11,369</td>
<td>11,307</td>
<td>13,665</td>
<td>36,341</td>
</tr>
<tr>
<td>Children (&lt; 5 years age)</td>
<td>32,285</td>
<td>54,658</td>
<td>53,006</td>
<td>139,949</td>
</tr>
<tr>
<td>Other (M &amp; F of &gt;5 years age)</td>
<td>52,578</td>
<td>53,310</td>
<td>142,442</td>
<td>248,330</td>
</tr>
<tr>
<td>Total services</td>
<td>329,320</td>
<td>548,301</td>
<td>568,490</td>
<td>1,446,111</td>
</tr>
</tbody>
</table>

Percentage of different types of health services offered by AHDS facilities (1996 - 1998)
<table>
<thead>
<tr>
<th>Service</th>
<th>Cases</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prenatal care</td>
<td>3993</td>
<td>29%</td>
</tr>
<tr>
<td>PID</td>
<td>2006</td>
<td>15%</td>
</tr>
<tr>
<td>Others</td>
<td>1854</td>
<td>14%</td>
</tr>
<tr>
<td>Menstrual disorder</td>
<td>1692</td>
<td>12%</td>
</tr>
<tr>
<td>Delivery</td>
<td>1427</td>
<td>10%</td>
</tr>
<tr>
<td>Postnatal care</td>
<td>1188</td>
<td>9%</td>
</tr>
<tr>
<td>Family planning</td>
<td>1137</td>
<td>8%</td>
</tr>
<tr>
<td>Referral</td>
<td>239</td>
<td>2%</td>
</tr>
<tr>
<td>Abortion</td>
<td>129</td>
<td>1%</td>
</tr>
</tbody>
</table>

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
- 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.
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

<table>
<thead>
<tr>
<th>Disease</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>ARI</td>
<td>30%</td>
</tr>
<tr>
<td>Diarrhea</td>
<td>27%</td>
</tr>
<tr>
<td>Malnutrition</td>
<td>17%</td>
</tr>
<tr>
<td>Malaria</td>
<td>5%</td>
</tr>
<tr>
<td>Others</td>
<td>21%</td>
</tr>
</tbody>
</table>
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**

- 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**

- 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 jeerab (2000m²) land for the construction of MCH/CHC facilities in Panjwai.
- For Tirinkote MCH, the community donated two jeerebs 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.
AHDS CONtributes to the rehabilitation of health infrastructure, promotes community health and provides health services.
PARTNERSHIP AND CO-ORDINATION WITH OTHER 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 cooperation 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 Shahwallkote 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.
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
COD 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 Medics 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.