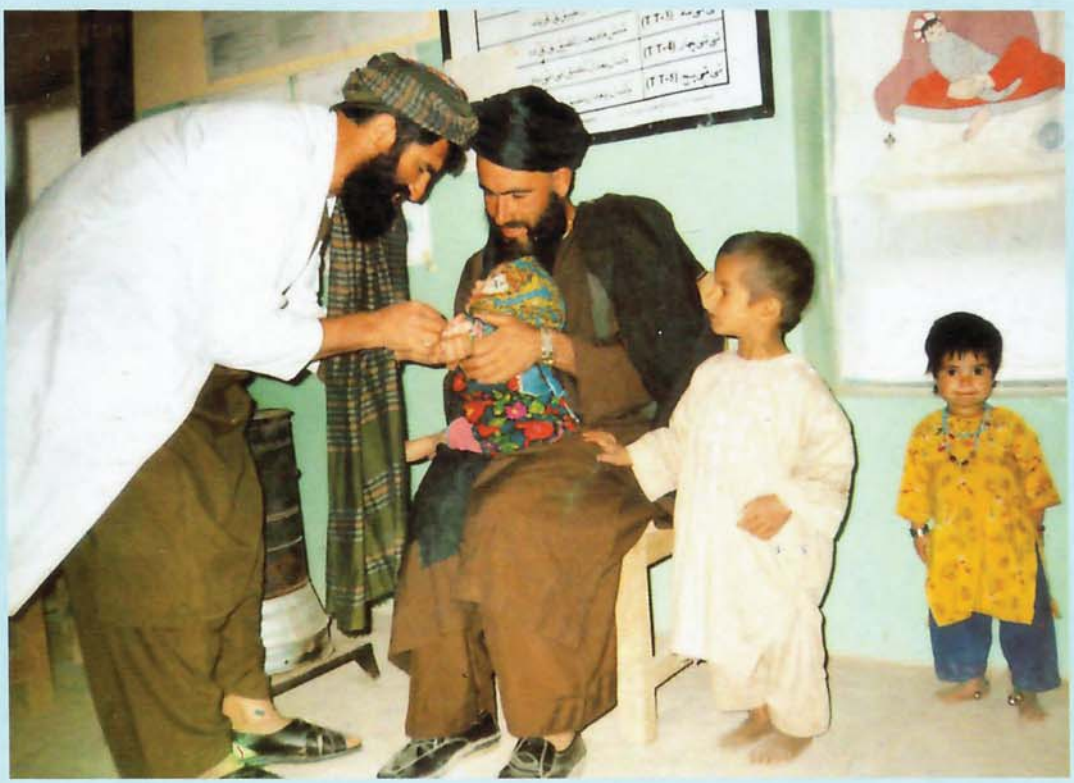
موسسه خدمات صحی و انکشافی افغان

Afghan Health & Development Services

# PRIMARY HEALTH CARE



# 1999 ANNUAL REPORT

# CONTENTS


| | |
|---|---|
| PREFACE | 1 |
| INTRODUCTION | 2 |
| AHDS' MISSION | 2 |
| AHDS' POLICIES | 3 |
| AHDS' TARGET AREA IN 1999 | 4 |
| COMMUNITY PARTICIPATION | 6 |
| COORDINATION WITH OTHER AGENCIES | 8 |
| HUMAN RESOURCE DEVELOPMENT | 9 |
| THE PRIMARY HEALTH CARE PROGRAM | 11 |
| HEALTH EDUCATION | 13 |
| MOTHER AND CHILD HEALTH CARE | 15 |
| IMMUNIZATION | 18 |
| WATER AND SANITATION | 20 |
| TREATMENT OF COMMON DISEASES | 22 |
| HEALTH STATISTICS | 23 |
| CONTROL OF COMMUNICABLE DISEASES | 25 |
| NUTRITION PROMOTION | 26 |
| PROVISION OF ESSENTIAL DRUGS | 27 |
| MONITORING AND EVALUATION | 28 |
| FINANCE | 30 |
| CONCLUSION | 31 |
| HEALTH FACILITIES | 32 |

# PREFACE

Another year has come and gone. Unfortunately, peace has not returned to the devastated war shattered Afghanistan. The word "PEACE" in Afghanistan is becoming an imaginary phenomenon that no one seems to have the ability to reach. Of course, PEACE has been the core subject of every national and international forum, seminar, workshop, conference, and symposiums, but so far none of the initiatives resulted in a mechanism to be used for bringing real PEACE and resolving the on going conflicts in the country.

AHDS in its own capacity strives to participate in the process of peace in a completely different manner. The organization has dedicated its efforts to humanitarian activities through offering Primary Health Care Services, building and rehabilitation of essential projects and structures as well as human resource development in the hope of providing a sustainable livelihood to target communities and paving the road for establishing real peace.

Despite of financial difficulties experienced during this reporting period, the tremendous work accomplished by AHDS is the result of endless efforts of AHDS' staff, especially the field staff who worked day and night with dedication and commitment.

I would like to take this opportunity to sincerely thank the staff of AHDS for a job well done. I would also like to extend my gratitude to AHDS' partners who provided generous monetary and technical support that enabled AHDS to achieve its set objectives.

Aziz R. Qarghah
Director

# INTRODUCTION

Afghan Health and Development Services (AHDS), an organization founded by Afghans, is a non-profit, non-governmental, and non-political organization. Since being established in April 1990, AHDS has concerned itself in rehabilitating Afghanistan's health sector and providing comprehensive primary health care services to the needy Afghan population. The organization has matured significantly in the past decade, having grown from operating eight health facilities with 30 staff in 1990/91, to running 38 health facilities (of various categories) with over 260 staff members in 2000. In the past ten years AHDS has established 56 health facilities in the following provinces: Logar, Nangarhar, Wardak, Kandahar, and Urozgan of which one is a Regional Training Center (RTC). 18 of the health facilities have been handed over to local authorities.

AHDS considers it a privilege that it has the opportunity to serve the bereft people of Afghanistan. AHDS provides ever-increasing access to health services through its health facilities especially for mothers and children in its target areas.

In the first half of 1999 AHDS was in a trying situation in that it was unable to secure definite funding. MSF-Holland backed part of AHDS' primary health care program in Urozgan Province. The rest of the health care program, which is based solely in Khandahar Province, was accepted in theory by the European Union but no funds were released at that time. In the previous year (1998) funding from the European Union was late so a part of the funding remained unused at the end of the year. AHDS appealed for a four-month extension into the year 1999. The European Union failed to respond at all to our proposal. Being disappointed by AHDS' primary donor, AHDS decided that to sustain its core program of mother and child it would have to cut costs. To obtain this goal AHDS ceased to operate 12 basic health posts (BHP) in February 1999. The European Union belatedly accepted that the program be continued into the first four months of 1999. For the remaining two months of the first half of 1999 AHDS sustained itself using its own resources.

The second half of 1999, AHDS was running on limited bridge funding. This funding was generously provided by mainly UNICEF and MSF-Holland but AHDS also received aid from WFP, UNOPS, and WHO. Since AHDS was running on bridge funding it was only able to keep its MCH centers, MCH/CHCs, BHCs and 12 BHPs operational thus caring for the needs of mothers and children but decreasing all other medical support to the bare minimum. Unfortunately the 12 BHPs, whose operations were suspended in the first half of 1999, were not reinitiated in that year.

## Mission Statement

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.

# AHDS' POLICIES

**Development/Rehabilitation:**
Due to the past 21 years of war and conflict, the socioeconomic infrastructure has been severely dismantled in Afghanistan. AHDS attempts to develop a satisfactory base for humanitarian activities through building and rehabilitation of essential projects and structures as well as human resource development. By the end of AHDS' mission the well installed projects with qualified manpower and fully equipped basic constructions can continue to serve the communities.

**Equitable service:**
Considering impartiality, AHDS serves all Afghan communities on an equitable basis regardless of ethnic, religious, and political concerns.

**Focus on women and children:**
Even before the war, Afghanistan's health and nutrition situation was among the worst in the world, especially for women and children. 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 (UNICEF). 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 networks. Therefore, AHDS always has brought the most vulnerable i.e. women and children in focus of any kind of assistance.

**Community based set-up:**
Close involvement of the communities will be promoted, fostered and sustained throughout each project cycle. Any project requires full community participation at every stage, to guarantee its sustainability. Without it, no services could or would be established. The community must be one, which is actively seeking, and contributing to, efficient social and developmental services for themselves. The active participation of local communities in the program is clearly indicative of their confidence as well as desire to protect and maintain the set-up.

**Affordability and effectiveness:**
Considering the poor socioeconomic infrastructure of Afghanistan, AHDS likes to utilize the most efficient, economic and essential technologies and programs. They should be simple enough to be easily handled and maintained and efficient enough to fulfill the basic demands of the target communities.

**Decentralized system:**
AHDS targets the most deprived, vulnerable, and remote communities, where they cannot reach the centralized facilities, which are almost always located in urban area with a limited catch-up spectrum. Therefore, AHDS starts the project from remote village and district levels in a centripetal manner. In this way the basic needs of communities will be prioritized and satisfied in a timely manner.

**Integrated approach:**
It is a proven fact that to reach the ultimate goal "health for all" is practical only through an integrated primary health care approach. AHDS would like to implement all of the 8 components of Primary Health Care in its target areas. While community participation and health education are kept in the center of AHDS' health activities, maternal and child health, immunization, control of locally endemic diseases, provision of essential drugs, treatment of common ailments, nutrition, and water/sanitation are important means of its health service delivery.

# TARGET AREAS IN 1999

The target areas for this project are in Southwest Afghanistan, more specifically Kandahar City, eight districts of Kandahar Province and two districts of Urozgan Province. An alphabetical enumeration of the areas is listed below:

1. Arghandab
2. Arghistan
3. Daman
4. Dand
5. Deh Rawood
6. Kandahar City (Loiwiala)
7. Khakrez
8. Maywand
9. Panjwaie
10. Shahwalikote
11. Tirinkote

## Beneficiaries:

The total number of beneficiaries in the target districts with primary health care activities was estimated at 1,056,905 individuals including:

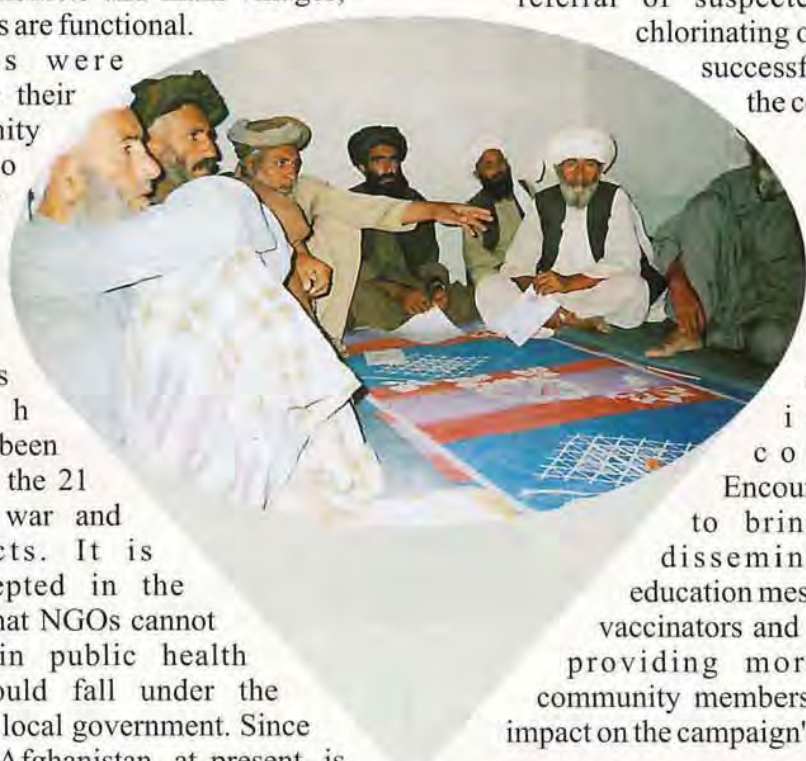
| | |
|---|---|
| 176,609 children | < 5 years |
| 64,000 children | < 2 years |
| 35,000 children | < 1 year |
| 197,430 women | 15 - 45 years of age |

(Based on Afghanistan Projected Total Population 1997, on the basis of UNIDATA 1990 population estimates).

# Location of AHDS' Health Facilities

# COMMUNITY PARTICIPATION

AHDS has managed community health committees in districts and main villages, where health facilities are functional. The committees were encouraged to urge their respective community members to participate and play an active role for their health and rehabilitation.



Afghanistan's health infrastructures have been disintegrated due to the 21 years of imposed war and internal conflicts. It is unanimously accepted in the development field that NGOs cannot indefinitely sustain public health programs that should fall under the responsibility of the local government. Since the government of Afghanistan, at present, is unable to meet the health care needs of its people, AHDS has fostered community participation to help partially sustain its health care program.

The health committees have monthly meetings in which AHDS' technical staff participates. The committees widely participated in the anti-cholera and polio eradication campaigns.

The community leaders' and community health committees' participation in controlling and preventing the spread of cholera helped to reign in the chances of an outbreak. Circulation of health education messages, early referral of suspected cases, and the chlorinating of water sources were successfully performed by the communities.

In the Polio eradication NIDs participation of the community health committees and other community members is highly commendable. Encouragement of people to bring their children, dissemination of health education messages, facilitating the vaccinators and volunteers' jobs, and providing moral assistance to community members had an outstanding impact on the campaign's success.

The community contributed for the improvement and provision of wells 14%, and for the provision of latrines 56%. The community contributions were both physical and financial. They helped the project by digging wells and its surrounding area, provision of locally available construction material like sand, gravel, rock, raw bricks, wood etc. and participation in the carrying of commodities where it is not possible by a vehicle.

Under the cost recovery scheme in clinics, monetary contributions from the communities were more than US$ 31,402 during year 1999. The community participation in the cost recovery program aims at creating the feeling of ownership amongst the population thus increasing the interest in developing and maintaining their health services and facilities.

The people eagerly participated in projects for promotion of their health status. The health committees encourage the community members to participate in making decisions directly effecting their own health and to help financially where feasible.

# CO-ORDINATION with other AGENCIES

Coordination with others in the field is vital for rehabilitation and development. AHDS tirelessly meets with other non-governmental organizations (NGO) and the United Nations agencies (UN) in order to promote co-ordination in the southwest of Afghanistan. AHDS works on its current relations with other organization and tries to cultivate new relations to ultimately help the people of the target southwestern region. AHDS has actively participated in the meetings of Afghan NGOs Coordination Bureau (ANCB), Agency Coordinating Body for Afghan Relief (ACBAR), South West Afghanistan and Baluchistan Association for Coordination (SWABAC), Afghanistan Programming Body (APB), Technical Coordination Committee (TCC), and Regional EPI Management Team (REMT) etc.

AHDS has had close contacts with United Nations Children's Fund (UNICEF), Medicine Sans Frontier (MSF), World Food Program (WFP), United Nations Office for Project Services (UNOPS), World Health Organization (WHO), Health Net International (HNI), Guardian, IbnSina, Afghan Development Association (ADA), Coordination of Humanitarian Assistance (CHA), the Danish Committee for Aid to Afghan Refugees (DACAAR), Mustashfa-e-Omar hospital, Alkhedmat, Afghan Doctors Association in Germany (ADAG), Islamic Aid Health Center (IAHC) and Ministry of Public Health (MOPH) to exchange ideas, share experiences and information, and coordinate their activities.

AHDS and UNOPS launched a joint TBA training program in the "4 Peace Districts" of Khandahar; Shahwalikote, Arghandab, Daman, and Dand. As a result of the co-operation between AHDS, Guardian and HNI it was agreed to integrate their vertical health programs into AHDS health facilities in the region. AHDS, at this moment, is carrying out the HNI's malaria control project in Shahwalikote, Arghandab, Maywand, Deh Rawood, and Panjwaie at mother and child comprehensive health centers (MCH/CHC) as an integrated part of its primary health care activities. Also the physiotherapy project of Guardian for the disabled is effectively serving the people of Arghandab District.

# HUMAN RESOURCE DEVELOPMENT

AHDS' regional training center (RTC) is designed to improve the quality of health services through appropriate human resource development. AHDS' RTC facilitates training/refresher courses, seminars, and workshops for both AHDS' staff and many other organizations that work in the southwestern region of Afghanistan. The WHO, UNICEF, MOPH, IbnSina, IAHC, Alkhidmat, Mutashfa Omar and ADAG organizations all make use of and gain from our RTC.

All training programs, scheduled at the beginning of the year were carried out. In addition to the scheduled training programs the RTC has constantly kept on top of the issues at hand by doing inspections on the quality of work at AHDS' health facilities and assessing the training needs of its staff. Based on this they review and adapt their teaching material when needed and offer extra training when and if the need arises.

The training plan was prepared on the basis of:

- Familiarization of newly employed staff with concepts of mother and child health, primary health care, health education, management etc.
- Determining the refresher course needs and contents during routine supervision
- National concerns like Breast Feeding week
- Seasonal widespread diseases like cholera, acute respiratory infection and so on.

# Activities of Regional Training Center in year 1999

**TRAINING WORKSHOP/SEMINARS:**

| Subject | Participants' groups and | No. | Duration | Organizations attended |
|---|---|---|---|---|
| February | | | | |
| Approval of treatment protocol workshop | District Health Officers | 12 | 2 days | AHDS |
| April | | | | |
| BHW refresher course | Basic Health Workers (BHW) | 10 | 13 days | AHDS |
| EPI workshop | Vaccinators | 10 | 2 days | MOPH, IbnSina, AHDS |
| Nutrition seminar | Doctors and mid-level health workers MLHW | 13 | 2 days | AHDS |
| May | | | | |
| PHC seminar | Doctors, MLHWs | 13 | 2 days | MOPH, ADAG, AHDS, IAHC, IbnSina |
| July | | | | |
| BHWs refresher course | BHWs | 10 | | AHDS |
| August | | | | |
| Breast feeding workshop | Female Health Workers | 121 | 7 days | All health organizations in Southwest region |
| Malaria seminar | Doctors and MLHWs | 18 | 2 days | AHDS, MOPH, ADAG, ARYA, Mustashfa-Omar, IbnSina, Alkhedmat, IAHC |
| September | | | | |
| Management workshop | DHOs and managers | 13 | 3 days | AHDS, MOPH, HNI, REMT |
| October | | | | |
| Training of Trainers (TOT) | TBA trainers & Health educators | 10 | 2 days | AHDS |
| November | | | | |
| Nursing refresher course | Nurses | 7 | 10 days | AHDS |
| Acute abdomen seminar | Doctors and MLHWs | 12 | 2 days | AHDS |
| December | | | | |
| Rational use of medicine | Doctors, MLHWs & Pharmacists | 10 | 2 days | AHDS |
| Safe Motherhood Initiative (SMI) workshop | Female Health Workers | 25 | 7 days | AHDS |

**OTHER ACTIVITIES:**

| | |
|---|---|
| Jan - Mar: | ➢ Planning and preparation of teaching material and learning aids. |
| June: | ➢ Participation in conducting oral rehydration therapy/health education system (ORT/HES) seminar for five provinces of the region, supported by WHO. |
| July: | ➢ Control of Diarrheal Diseases (CDD) on job training for staff of Mirwais hospital.<br>➢ Participation in development of a plan for control of diarrhea and cholera in the region.<br>➢ Translation and distribution of Cholera prevention practical guidelines for health educators and BHWs. |
| August: | ➢ Participation in technical coordination meeting.<br>➢ Participation in one-week breast-feeding campaign.<br>➢ Participation in polio eradication NID (national immunization day) micro planning in the region. |
| September: | ➢ Provision and distribution of new health education material. |
| October: | ➢ Participation in mid term review of health plan in the region. |
| December: | ➢ Review and update of health education prime massages manual.<br>➢ Revision of AHDS treatment protocol. |

# The PRIMARY HEALTH CARE program

## Overall Objective:

The overall objective of the AHDS Integrated Community Based Primary Health Care Program is to reduce morbidity and mortality rates with special focus on mother and child by increased accessibility to curative, preventive, and promotive care through cost effective, affordable primary health care interventions.

## Specific objectives in year 1999:

1. To provide comprehensive health services to the target populations through fully operational AHDS health facilities.

2. To reduce the incidence of the main vaccine preventable diseases (tuberculosis, poliomyelitis, pertusis, diphtheria, measles, and tetanus) by increasing immunization services to the target populations.

3. To improve community members' behavior and attitudes towards health related issues and problems, especially within the female population regarding the importance of using safe drinking water and acquiring proper sanitation habits.

4. To improve safe birth practices by increased access to trained traditional birth attendants (TBA) in remote areas.

5. To improve the capability of the local health work force by offering continuous training.

6. To increase community participation and support in the rehabilitation and operation of their health network.

7. To provide safe drinking water facilities, tackling the root causes of water born diseases and non-hygienic conditions, by digging and improving 150 shallow wells and installation of hand pumps.

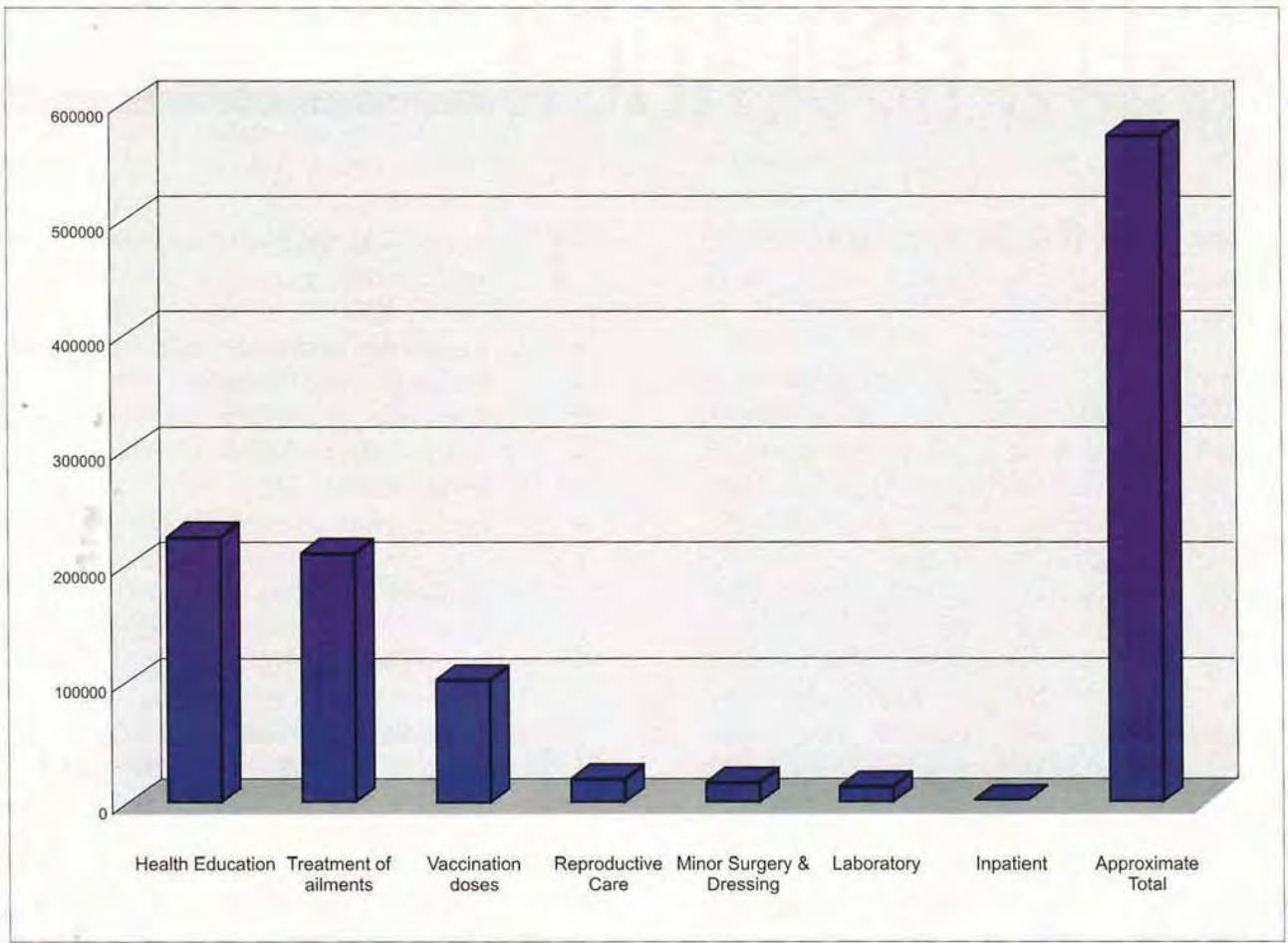
8. To promote the use of sanitary latrines in communities by recruiting 750 families to accept and use sanitary latrine facility at their homes.

AHDS has strived to bring all the 8 components of the primary health care objectives to the target areas. Even though all the components were not launched in all the target areas, still the majority of them are in practice. AHDS was able to provide water and sanitation to only two target districts. AHDS was not able to address the nutrition component adequately.

### COMPONENTS OF PRIMARY HEALTH CARE

1. Health Education
2. Water and Sanitation
3. Immunization
4. Nutrition
5. Maternal and Child Health
6. Control of Communicable Diseases
7. Provision of Essential Drugs
8. Treatment of Common Diseases

Different types of health services provided by AHDS health facilities are summarized in the chart on top of next page.




Give a hand
to participate,
by endowing public health,
in emancipating
health and peace!

# HEALTH EDUCATION

AHDS health network was able to provide health education to 226,410 people during the reporting period.

Both female and male educators have provided health education to individuals visiting health facilities, to community members in villages as well as to students attending schools and madrasas. In order to reach more people, AHDS hired two couples (married) for Tirinkote and Deh Rawood districts to do door-to-door health education that focused on safe drinking water, sanitation, and hygiene related issues. The 761 trained traditional birth attendants (TBA) and outreach vaccination teams also played an important role in the health education efforts. In addition, AHDS circulated a large quantity of printed health education material i.e. leaflets and calendars, which have influenced the behavior of the beneficiaries residing in the target areas.

The health education sessions included the following prime messages:

- Acute respiratory tract infection (ARI)
- Breast feeding/Weaning
- Correct usage of medicine
- Diarrhea/Dehydration
- Drug abuse
- Family planning
- Hygiene/Sanitation
- Immunization
- Mine awareness
- Nutrition/Malnutrition

AHDS successfully implemented the main components of PHC, health education, increased awareness of community members about the importance of clean water and sanitation. Due to the needs of the communities the top priorities for health education in the second and third quarters were cholera/acute diarrhea, oral re-hydration and water/sanitation.

Teaching people how to use ORS, and informing them about the risks of diarrhea and the importance of its prevention took place at health facilities and within the communities. The technical staff at the health facilities and community members widely participated in the chlorination of water sources.

Throughout the year the staff of AHDS tried not to miss any opportunity for social mobilization. The staff took advantage of the national immunization days (NID), during the second and fourth quarters of the year, to educate the people of the target areas about polio and means of eradicating it.

The national week of breast-feeding was in the first week of August. AHDS emphasized the value of this practice throughout the region. One of AHDS' female doctors had the chance to participate in the "breast feeding workshop" for master trainers conducted by UNICEF/WHO in Peshawar. Then she facilitated training seminars for all female health providers in the Southwest region with the support of UNICEF, WHO and MOPH. A total of 121 people participated in the seminars. During the promotional week, all of AHDS' technical staff dedicated most of their time in disseminating prime messages on breast-feeding. AHDS fully participated in making the breast-feeding week a special event in its health facilities and in the communities where the organization provides services.

Community health committee members and other village representatives passed out messages promoting breast-feeding as well as cholera prevention and polio eradication at social gatherings such as Friday prayers. Due to this kind of participation the community awareness as a whole increased. Because of this increase in awareness people were more willing to bring their children for polio vaccinations and chlorinate water supplies. AHDS' field office on a daily basis receives more and more requests for the provision of more wells and latrines.

AHDS found the chance to include sexually transmitted diseases (STD) into the routine health education prime messages because of frequent incidences of vaginitis and pelvic inflammatory diseases.

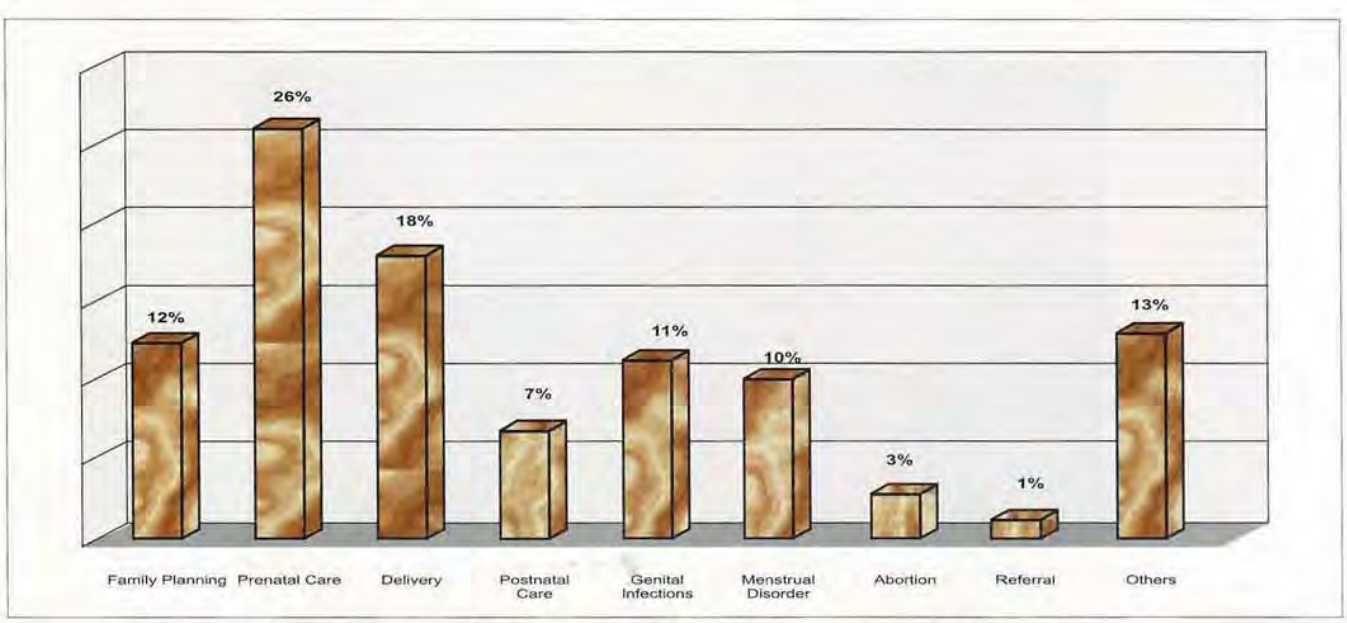
# MOTHER and CHILD HEALTH

AHDS' objective is to reduce maternal and child mortality rates through its health services offered mainly at MCH centers and by trained traditional birth attendants (TBA).

AHDS has 10 maternal and child health care centers (MCH) as well as 761 TBAs in the target southwestern region of Afghanistan. To facilitate the needs of the mothers and to assure efficient health services AHDS has posted a female TBA master trainer in its regional office who is in constant contact with the MCH coordinator at the main office.

The MCH clinics provide health education, family planning, prenatal care, emergency obstetric care, postnatal care, management of childhood diseases, and treatment of gynecological problems. MCH centers are sufficiently manned by female staff, which is made up of M.D. doctor, nurse, health educator, TBA trainer, and other support staff. In addition to the MCH clinics all AHDS health facilities cover the necessities for children's health.

All in all, 77,586 women and 83,856 children were treated in AHDS health facilities during 1999. The number of beneficiaries for maternal services was 19,494. From the total maternal health care the following percentages are outstanding: prenatal care 26%, delivery at clinic and home 18%, family planning 12% and genital system infections 11%. Only 1% of all the obstetric/gynecology cases attended AHDS' MCH centers needed to be referred to Mirwais hospital located in Kandahar City, which receives support from ICRC and MSF.




Percentage of different maternal health cares out of total 19,494 cases recorded in AHDS' MCH centers

## Traditional Birth Attendants:

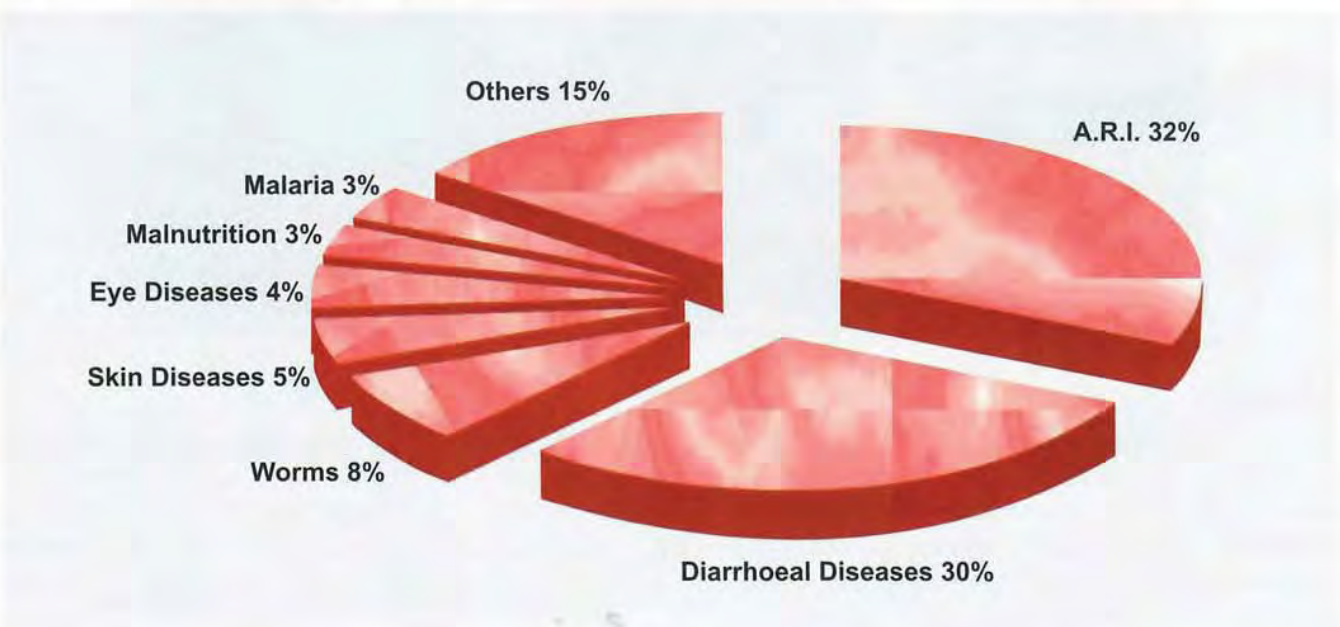
The training of traditional birth attendants has proved to be a culturally acceptable and cost effective way to promote the save motherhood initiatives in the target area. The Daie, old women of villages who help mothers during the delivery of babies, are retrained by AHDS TBA trainers according to the WHO guidelines in a two-week course after which they each receive an initial TBA kit. This year alone AHDS has trained 241 new TBAs. This brings the total from 520 TBAs to 761. The TBA trainers of each district supervised the TBAs on a regular basis.

While supervising the TBA trainers would provide the TBAs with refresher courses and supplies where needed. TBAs greatly benefited from the supervision and monthly meetings. The monthly meeting served as a good opportunity for data collection, refresher training, and the exchange of ideas and experiences between participants. Assisting mother before, during, and after delivery do not sum up the usefulness of the TBAs. They also provided a good source for promoting health education on prenatal care and diarrheal diseases/dehydration. They also referred cases with potential complications to MCH centers.

## Children:

**39.4%** of all the beneficiaries of AHDS' curative health services were children of less than 15 years of age. Management of childhood illness is integrated into AHDS' primary health care service as an important part of MCH. AHDS provides treatment for sick children and essential medication for free. Vaccination against six killer childhood diseases and health education especially on acute respiratory infection, diarrheal diseases and nutrition are valuable steps that are taken to improve health of the children.

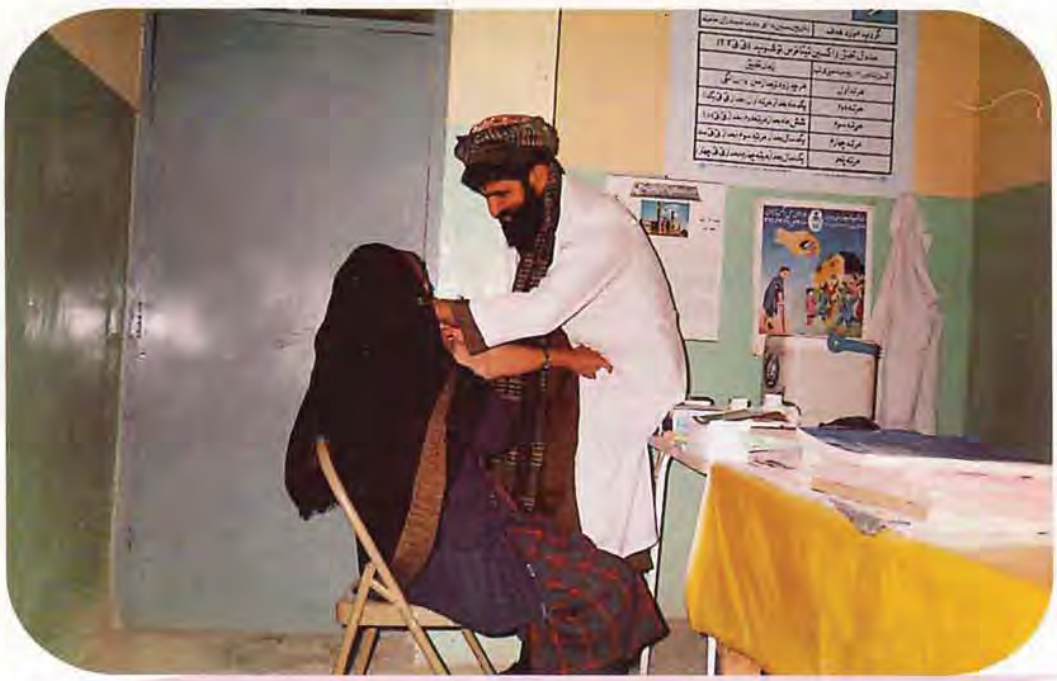
The under five years age group children is the most vulnerable and has higher morbidity and mortality rates. Disease patterns in this age group, recorded in AHDS facilities during the reporting period, show that instances of acute respiratory infection (ARI) and diarrheal disease (DD) are the most frequent followed by worms, skin diseases, eye diseases, malnutrition and malaria. This shows that increased service and supplies should be dedicated to the prevention and curing of ARI and DD.




Percentage of top 7 diseases among less than five years age children treated in AHDS' health facilities in 1999

# IMMUNIZATION

AHDS strives to reduce the incidences of vaccine-preventable diseases in the target areas. There are 12 active Expanded Program of Immunization (EPI) fixed centers that work out of AHDS' MCH and basic health centers (BHC). UNICEF supported this project by providing vaccines, cold chain, incentives, and training of the staff. Each of the 12 fixed centers are staffed by two male vaccinators who perform in-clinic and out reach activities. The vaccinations provided are for the six-killer diseases of children: Tuberculosis, Poliomyelitis, Diphtheria, Pertusis, Tetanus, and Measles. On top of this AHDS employed female vaccinators to work in MCH centers who attract a larger number of women. This helped especially in protecting against maternal tetanus. In this reporting period, only a few cases of measles, tuberculosis, and poliomyelitis were reported but no cases of diphtheria, pertusis, and tetanus. Male vaccinators arranged to spend more time on outreach activities, which consequently increased the immunization coverage. The out-reach program is carried out from the EPI fixed locations on a regular basis (8-12 days per month) to better serve remote areas and increase immunization coverage.



AHDS is an active member of the Regional EPI Management Team and the Provincial EPI Management Team in the Southwestern region. The organization has been directly involved in the daily supervision of EPI activities, vaccine transportation to the fixed centers, and payment of incentives to vaccinators.

AHDS has had the honor to participate actively in Polio eradication national immunization days in Kandahar and Urozgan provinces. AHDS district health officers worked as district NID coordinators and managed the implementation of the vaccinations. It was an honor for AHDS to work for such a valuable measure, which helps to save the lives of children and assists to prevent future deaths and disabilities. Our assistant project coordinator was assigned as Provincial NID Coordinator for Urozgan Province. He has done an exceptional job and has arranged the first social mobilization march in Tirinkote. Polio eradication NIDs supported by WHO and UNICEF were successfully carried out by AHDS in its target areas. There were two rounds of national immunization days, one in spring and another in fall, with two subsequent polio vaccine doses one month apart. The spring NIDs were on May 9-11 and June 13-15. The autumn NIDs were on October 25-27 and November 27-29. These campaigns were a major step towards a better and healthier life for children.

Although the outcome of EPI is not within the range of what was projected for the area, the total number of vaccine doses administered shows a gradual upward trend, which gives AHDS reason to be optimistic for the future.

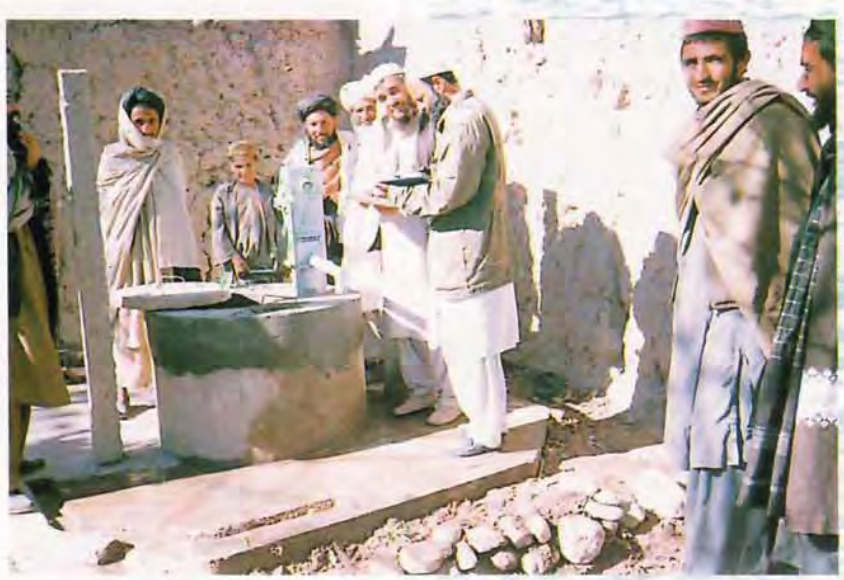
# WATER and SANITATION

Integration of a water and sanitation component of AHDS' Primary Health Care Program allowed us to better reach both goals. AHDS through a pilot project planned to dig new wells and upgrade existing wells by adding pumps. On top of this AHDS constructed 750 sanitary latrines in Tirinkote and Deh Rawood districts of Urozgan Province. This was to help prevent water-borne and sanitation-related diseases and as a result decrease the morbidity and mortality rates in the target areas.

In rural area, people have traditionally relied on irrigation canals, open ponds, Karezs (underground tunnel), rivers, springs, and unprotected shallow wells as the source of their water needs. Unfortunately, most of these water supplies are contaminated and are not potable.

The women and children are usually the ones responsible for attaining the water needed in the households. A lot of time and effort is wasted in carrying water from the source to the house as the water sources are usually far from the houses. It goes without saying that this task becomes very burdensome for pregnant women and young children especially in hilly areas. Therefore, wells providing safe water sources in villages not only prevent disease but it also increases the quality of life of the population of the target area.

In remote areas of the target districts, people are not accustomed to use latrines. The men use open fields far from their houses and the women defecate in designated open areas in their compounds. Careless spread of human waste is a major contributor to the transmission of infectious disease. In addition it is very difficult for women to find a private site, which creates unnecessary psychological burden.



In the past five years, that AHDS has worked in Tirinkote and Deh Rawood, AHDS has observed relatively high morbidity and mortality rates, and found that water-borne diseases are a major cause. Due to inadequate supply of potable water and poor sanitation practices cholera cases have been a constant threat to the residents of these areas.

The first stage of the project was digging and improvement of 150 wells in target villages, which was carried out from mid May 1999 to August 31 of 1999. In the second stage the wells were improved more to ensure water safety and November and December 1999 to AHDS regional office. The installation process of hand pumps was started immediately, and 19 were completed by end of December. 23 latrines were built and people are using them in both target districts by the end of December. By this project, AHDS provided access to sanitary latrines for family members including women, children and elders.

The project will be hopefully completed in next 3 months (continuation in year 2000).

# TREATMENT of COMMON DISEASES

213,029 patients were treated in AHDS health facilities in year 1999. It is important to note that women and children were the major beneficiaries of the services provided thus indicating very good results in reaching the objectives of the program. 75.8% of the people receiving curative services were women and children.


Treatment of common diseases is one of the important components of primary health care. The reason for this is that not all people are familiar with community health, and will not readily believe that preventative and promotional measures will increase their health until they see it for themselves. AHDS provides medical consultation and free essential medication. It should be mentioned that to encourage community participation a trivial fee has been charged for each visit by a patient.

The curative services are provided by AHDS' 2 mother and child health centers, 1 comprehensive health center, 8 mother and child/comprehensive health centers, 2 basic health centers and 12 basic health posts in Kandahar and Urozgan provinces.

The curative services include treatment of common and locally endemic diseases, minor surgery, provision of medicines, and routine laboratory examinations. The MCH/CHC facilities are equipped to deal with emergency cases around the clock, with night staff on duty.

Considering the budgetary constraints, and knowing that AHDS was running on bridge funding, the functional health facilities have helped greatly the people of the target areas.

The most common diseases among children found in AHDS target areas were acute respiratory tract infection and diarrheal diseases, which made all together 62% of cases in the vulnerable less than 5 years age group. The most common morbidity causes for adults were also acute respiratory tract infection and diarrheal diseases. In addition peptic diseases, musculo-skeletal disorders, anemia, malaria and urinary tract infection were predominant burdens of people's health.

# AHDS health statistics during 1999 in Kandahar and Urozgan Provinces

| | <1, Male | <1, Female | 1-4, Male | 1-4, Female | 5-14, Male | 5-14, Female | >15, Male | >15, Female | Total |
|---|---|---|---|---|---|---|---|---|---|
| January | 851 | 660 | 1433 | 1168 | 2224 | 1598 | 3652 | 3962 | 15548 |
| February | 1063 | 817 | 1530 | 1227 | 2122 | 1754 | 4343 | 7003 | 19859 |
| March | 612 | 497 | 1227 | 1093 | 1423 | 1290 | 4881 | 5093 | 16116 |
| April | 966 | 727 | 1420 | 1121 | 1826 | 1670 | 4094 | 5629 | 17453 |
| May | 907 | 910 | 1671 | 1461 | 1951 | 1697 | 5036 | 8025 | 21658 |
| June | 638 | 495 | 1074 | 984 | 1842 | 1279 | 4519 | 5161 | 15992 |
| July | 777 | 740 | 1398 | 1164 | 1752 | 1164 | 4959 | 6732 | 18686 |
| August | 755 | 662 | 1209 | 1121 | 1426 | 1265 | 3810 | 6872 | 17120 |
| September | 709 | 626 | 1556 | 1184 | 1770 | 1207 | 4484 | 8017 | 19553 |
| October | 948 | 782 | 1328 | 1009 | 1618 | 1187 | 4511 | 8153 | 19536 |
| November | 668 | 623 | 995 | 831 | 1296 | 1126 | 3500 | 6245 | 15284 |
| December | 606 | 559 | 1063 | 929 | 1398 | 1177 | 3798 | 6694 | 16224 |
| Total | 9500 | 8098 | 15904 | 13292 | 20648 | 16414 | 51587 | 77586 | 213029 |
| Percentage | 4.5 | 3.8 | 7.5 | 6.2 | 9.7 | 7.7 | 24.2 | 36.4 | 100.0 |

| Women > 15 | Children < 15 | Women and Children | Men > 15 |
|---|---|---|---|
| 77586 | 83856 | 161442 | 51587 |
| 36.4% | 39.4% | 75.8% | 24.2% |

## Top 7 diseases among <5 years age group

| | January | February | March | April | May | June | July | August | September | October | November | December | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| A.R.I. | 1911 | 1871 | 1410 | 1065 | 971 | 945 | 761 | 1044 | 1063 | 1350 | 1211 | 1334 | 14936 |
| Diarrhoeal diseases | 696 | 757 | 672 | 1311 | 2356 | 1368 | 1642 | 1541 | 1106 | 1025 | 728 | 740 | 13942 |
| Malnutrition | 149 | 152 | 174 | 198 | 167 | 149 | 84 | 86 | 95 | 147 | 149 | 82 | 1632 |
| Malaria | 84 | 104 | 90 | 115 | 233 | 191 | 210 | 192 | 148 | 125 | 69 | 23 | 1584 |
| Worms | 366 | 594 | 355 | 455 | 337 | 212 | 158 | 130 | 329 | 254 | 97 | 261 | 3548 |
| Eye Diseases | 145 | 192 | 101 | 115 | 91 | 123 | 64 | 109 | 415 | 298 | 153 | 192 | 1998 |
| Skin diseases | 204 | 310 | 173 | 209 | 172 | 178 | 152 | 177 | 179 | 233 | 106 | 110 | 2203 |

## Top 7 diseases among >5 years age group

| | January | February | March | April | May | June | July | August | September | October | November | December | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| A.R.I. | 3397 | 4173 | 2279 | 2345 | 2140 | 2037 | 2405 | 2204 | 2758 | 3270 | 3319 | 3626 | 33953 |
| Malria | 273 | 438 | 341 | 570 | 1210 | 1210 | 1185 | 876 | 697 | 620 | 264 | 192 | 7876 |
| Diarrhoeal diseases | 891 | 1228 | 1021 | 1244 | 1588 | 1422 | 1835 | 1563 | 1197 | 883 | 791 | 765 | 14428 |
| Musculoskeletal Disorders | 1065 | 1055 | 698 | 1063 | 942 | 979 | 947 | 989 | 571 | 852 | 791 | 568 | 10520 |
| Urinatry Tract Infection | 312 | 354 | 394 | 517 | 624 | 554 | 533 | 510 | 641 | 616 | 628 | 446 | 6129 |
| Peptic Diseases | 1036 | 1258 | 929 | 1075 | 1244 | 1162 | 1321 | 1193 | 1236 | 1189 | 998 | 1872 | 14513 |
| Anaemia | 240 | 648 | 434 | 672 | 694 | 571 | 607 | 802 | 777 | 997 | 859 | 648 | 7949 |

## In - patients

| | January | February | March | April | May | June | July | August | September | October | November | December | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Total | 104 | 134 | 81 | 89 | 282 | 112 | 327 | 261 | 97 | 96 | 89 | 89 | 1761 |

## Laboratory

| | January | February | March | April | May | June | July | August | September | October | November | December | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Total | 342 | 976 | 913 | 931 | 1586 | 1980 | 1190 | 1754 | 731 | 1517 | 629 | 629 | 13178 |

## Minor Surgery and Dressing

| | January | February | March | April | May | June | July | August | September | October | November | December | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Total | 1272 | 1027 | 1297 | 1268 | 1357 | 1410 | 1598 | 1557 | 2010 | 1178 | 945 | 945 | 15864 |

## Health Education

| | January | February | March | April | May | June | July | August | September | October | November | December | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Total | 16725 | 21458 | 18123 | 18457 | 21984 | 17729 | 20233 | 19226 | 19971 | 20154 | 15509 | 16841 | 226410 |

## Immunization

| | January | February | March | April | May | June | July | August | September | October | November | December | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| BCG, < 1year | 898 | 840 | 716 | 683 | 601 | 473 | 215 | 505 | 590 | 578 | 549 | 621 | 7269 |
| OPV1 + DPT1, < 1 | 823 | 780 | 517 | 497 | 586 | 507 | 472 | 490 | 928 | 639 | 557 | 648 | 7444 |
| OPV2 + DPT2, < 1 | 531 | 541 | 442 | 445 | 527 | 394 | 379 | 449 | 435 | 525 | 507 | 632 | 5807 |
| OPV3 + DPT3, < 1 | 514 | 473 | 530 | 560 | 420 | 435 | 424 | 437 | 533 | 448 | 466 | 605 | 5845 |
| OPV4, < 1 | 800 | 389 | 298 | 316 | 225 | 261 | 123 | 240 | 315 | 278 | 258 | 354 | 3857 |
| Measles, < 1 | 396 | 745 | 585 | 531 | 354 | 360 | 234 | 412 | 482 | 490 | 512 | 93 | 5194 |
| BCG, 1-2 years | 861 | 885 | 659 | 645 | 411 | 482 | 516 | 507 | 487 | 388 | 270 | 457 | 6568 |
| OPV1 + DPT1, 1-2 years | 823 | 902 | 528 | 504 | 404 | 509 | 502 | 542 | 439 | 461 | 281 | 490 | 6385 |
| OPV2 + DPT2, 1-2 years | 585 | 487 | 445 | 451 | 436 | 437 | 313 | 430 | 425 | 305 | 274 | 488 | 5076 |
| OPV3 + DPT3, 1-2 years | 731 | 435 | 483 | 517 | 399 | 382 | 350 | 311 | 492 | 376 | 260 | 464 | 5200 |
| OPV4, 1-2 years | 880 | 367 | 273 | 288 | 233 | 246 | 261 | 217 | 248 | 252 | 93 | 274 | 3632 |
| Measles, 1-2 years | 1797 | 2764 | 1100 | 938 | 481 | 491 | 426 | 508 | 571 | 535 | 357 | 764 | 10732 |
| Women, TT1 | 875 | 1182 | 1084 | 1102 | 1245 | 1095 | 954 | 831 | 898 | 831 | 694 | 595 | 11386 |
| Women, TT2 | 693 | 798 | 557 | 841 | 940 | 640 | 719 | 718 | 631 | 699 | 395 | 440 | 8071 |
| Women, TT3 | 319 | 610 | 637 | 652 | 572 | 377 | 399 | 438 | 407 | 596 | 389 | 369 | 5765 |
| Women, TT4 | 390 | 375 | 360 | 336 | 489 | 342 | 367 | 226 | 324 | 351 | 300 | 196 | 4056 |
| Women, TT5 | 252 | 301 | 236 | 226 | 388 | 185 | 237 | 251 | 162 | 204 | 195 | 112 | 2749 |

## Reproductive Health

| | January | February | March | April | May | June | July | August | September | October | November | December | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Family planning | 144 | 242 | 173 | 165 | 227 | 173 | 159 | 150 | 164 | 195 | 213 | 344 | 2349 |
| Menstrual disorder | 158 | 184 | 143 | 109 | 192 | 188 | 155 | 133 | 134 | 171 | 167 | 131 | 1865 |
| Prenatal care | 278 | 484 | 302 | 299 | 368 | 412 | 372 | 449 | 595 | 573 | 416 | 505 | 5053 |
| Postnatal care | 83 | 147 | 95 | 100 | 114 | 132 | 60 | 86 | 220 | 91 | 60 | 86 | 1274 |
| Delivery | 20 | 57 | 13 | 5 | 12 | 12 | 18 | 14 | 19 | 26 | 120 | 28 | 344 |
| Delivery by TBA | 324 | 262 | 275 | 328 | 231 | 154 | 172 | 423 | 300 | 247 | 249 | 192 | 3157 |
| Pelvic Inflammatory Diseases | 150 | 217 | 150 | 154 | 168 | 108 | 123 | 196 | 159 | 246 | 216 | 311 | 2198 |
| Pregnancy toxemia | 3 | 9 | 4 | 3 | 11 | 7 | 12 | 4 | 6 | 10 | 0 | 9 | 78 |
| Dysfunctional Uterine Bleeding | 40 | 50 | 61 | 62 | 53 | 66 | 22 | 35 | 78 | 70 | 39 | 101 | 677 |
| Abortion | 14 | 55 | 32 | 17 | 69 | 61 | 38 | 37 | 74 | 40 | 32 | 45 | 514 |
| Infertility | 47 | 102 | 50 | 61 | 77 | 89 | 63 | 61 | 92 | 68 | 80 | 55 | 845 |
| Others | 64 | 65 | 87 | 48 | 36 | 94 | 98 | 75 | 134 | 88 | 72 | 48 | 909 |
| Referral | 18 | 14 | 24 | 14 | 19 | 17 | 21 | 18 | 27 | 17 | 17 | 25 | 231 |
| TOTAL | 1343 | 1888 | 1409 | 1365 | 1577 | 1513 | 1313 | 1681 | 2002 | 1842 | 1681 | 1880 | 19494 |

# CONTROL of COMMUNICABLE DISEASES

AHDS has actively participated in control of communicable diseases in Urozgan and Kandahar provinces.

9,460 malaria cases were found and successfully treated in the target areas. AHDS provides health education on malaria eradication, gives anti-malarial drugs, and distributes bed-nets to the community members. Health Net International (HNI) supports malaria eradication program by providing technical advice, anti-malarial drugs, subsidized drug impregnated bed-nets, and incentive for health workers in 5 districts.

The most critical problem of the year was the cholera outbreak in the region, which caused a great deal of suffering among the afflicted populations. A total of 28,379 cases of acute diarrhea were recorded in AHDS facilities, which were treated carefully to avoid further spreading the disease. 963 cases of suspected cholera including 9 deaths were reported from AHDS target districts. The incidence was respectively higher in Tirinkote, Maywand, Deh Rawood, and Arghistan districts. The contamination is usually caused by unsafe water sources and inadequate sanitation. Fortunately, the outbreak came under control with the help of the timely assistance of MSF-H and WHO. The epidemic was calmed down in October. Participation of the community health committees in controlling and preventing the spread of cholera was essential in reducing the outbreak.

There were national immunization days for polio eradication supported by WHO and UNICEF in spring and autumn. Polio is one of the prevalent and most devastating diseases among children, in Southwest region. AHDS was one of the main stakeholders in the campaigns with successful results in Kandahar and Urozgan provinces. The community members were very interested and responded well to the NIDs.

WHO supports our tuberculosis control program in Shahwalikote district by providing anti-tuberculosis drugs, laboratory facility and technical advice.

# NUTRITION PROMOTION

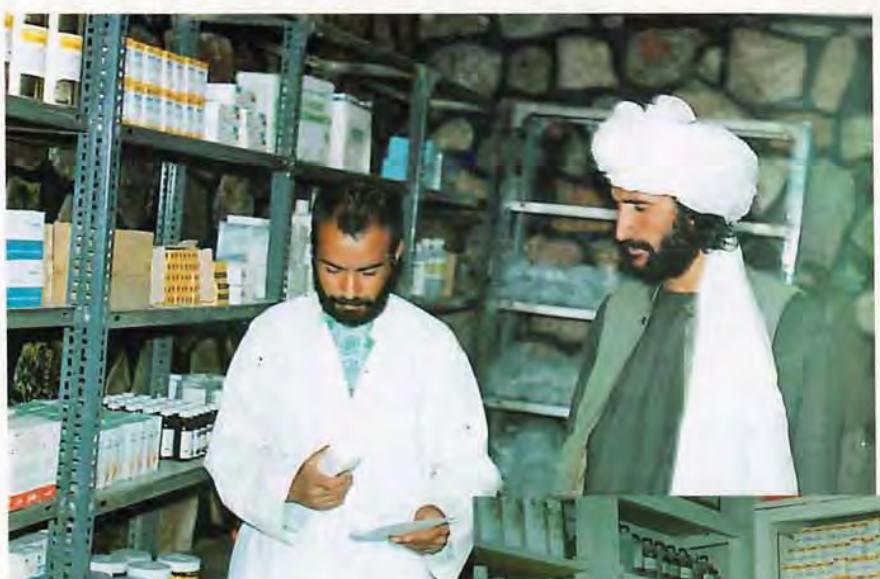
The only but vital measure for nutrition promotion that AHDS has been able to handle yet is health education. The health educators used group discussions, flip charts, and food demonstrations for propagation of good nutrition habits for pregnant and lactating women as well as children.

The prime messages consist of the importance of three nutritious food groups i.e. body building foods (e.g. protein containing foods), energy foods (e.g. fat and carbohydrate containing foods) and protective foods (e.g. vitamin and mineral containing foods). Female and male health educators instructed people, especially mothers about the steps for weaning babies and what supplementary food should be given to pregnant and lactating women. Food demonstrations were done once a week in Mother and Child Health clinics to show mothers how to provide clean complete nutritious meals from locally available food. In sessions the mothers and health educators cooked porridge and beans/rice mixture and present children at the clinic consumed it. World Food Program support was much appreciated.

**A large proportion of morbidity rate among women and children in developing countries is caused directly or indirectly by undernutrition.**

# PROVISION OF ESSENTIAL DRUGS

AHDS provides most of the essential drugs for patients who come to the health facilities. The drugs are chosen according to WHO's list of essential drugs compared to what the field requirements are. Common diseases in the area indicate, which types and quantity of medicine are required. To be specific about the quantity, the number of cases is multiplied by the dose of drug per day, which is in turn multiplied by the number of treatments per day. Different lists are curtailed according to professional expertise and patient load of different types of health facilities. The medicines were purchased from Pakistan multinational companies on a quarterly basis. There are 2 lists of Pakistan based companies prepared by MOPH. One indicates the companies, which are recognized as producers of quality drugs based on standards, and the other shows low quality medicine provider companies. AHDS always considered the lists and almost all of the medicine provided in the year 1999 were from the acceptable multinational companies.



# MONITORING EVALUATION

The monitoring and evaluation of the project was carried out by all feasible means. Ensuring quality and coverage of offered services, supervision and monitoring of overall project activities as well as health services are carried out regularly. The project coordinator, technical manager and staff of the regional training center performed regular visits on monthly basis. In addition the technical support unit (MCH coordinator and medical coordinator) and finance team (finance director and accountant) from the main office have visited the project sites several times, supervised the project implementation and activities and provided the required technical support and guidance.

In addition a consultant with the financial support of MSF-Holland was hired to objectively assess the overall managerial aspects of the organization. AHDS has already started the review of some basic pertinent managerial policies based on the consultants' findings and recommendations.

An evaluation team from International Rescue Committee (IRC) was assigned by the Netherlands Refugee Foundation to evaluate the pilot water & sanitation project of AHDS in Urozgan Province in December. Generally, outcome of this project is evaluated effective and a potential to aid additional improvements in the future. Some shortcomings are also pointed out by the team, which will be considered in the next projects to adapt a higher standard of work.

UNICEF and WHO staff have visited field activities and provided valuable technical advice for improvement of services.

To insure the quality of services and performance of AHDS' health facilities, MSF-Holland's expatriate professional staff assessed the programs in Kandahar and Urozgan Provinces, which showed satisfactory performance of AHDS' health services and produced meaningful recommendations to improve the services. The assessment of Kandahar MCH centers was done in May 1999, and assessment of Urozgan primary health care project in September 1999.

MOPH staff and local authorities also supervised several times and were impressed by progress of the work.

# FINANCE

AHDS experienced somewhat rigid financial ups and downs during 1999. It was very difficult to cope in the vague situation where European Union (EU) had not sent any funding for operations 1999 and they did not give timely green light for the requested no cost extension by AHDS. It resulted in the closure of 12 basic health posts in Kandahar Province and limited the health services in the rest of health facilities for the first six months. In June 99, European Union decided to approve the no cost extension for the fist four months of 1999. Fortunately, the Urozgan part of the health operation throughout the year was financed by MSF Holland. Also Kandahar operation was financed by co-funding from humanitarian organizations mainly UNICEF and MSF-H as well as WFP, UNOPS and WHO for the second half of the year.

Stichting Vluchteling (SV) and UNICEF funded a pilot water and sanitation project in 2 districts of Urozgan Province.

The following table summarizes financial situation and donors of AHDS during year 1999.

| BUDGET LINES: | DONORS' CONTRIBUTION (IN US$) | | | | | | | | | TOTAL |
|---|---|---|---|---|---|---|---|---|---|---|
| | AHDS | EU | MSF-H | UNICEF | SV | UNOPS | WFP | WHO | COMMUNITY | |
| Services | | 1,299 | 19,484 | 9,924 | 3,600 | | | | | **34,307** |
| Supplies | | 18,223 | 73,713 | 28,604 | 630 | 10,215 | 5,100 | 6,000 | | **142,485** |
| Construction | | 121 | | 12,338 | 7,162 | | | | | **19,621** |
| Operation | 21,444 | 48,190 | 154,424 | 30,232 | 18,508 | | | | 31,402 | **304,200** |
| TOTAL | **21,444** | **67,833** | **247,621** | **81,098** | **29,900** | **10,215** | **5,100** | **6,000** | **31,402** | **500,613** |

# CONCLUSION

The fifth year of AHDS efforts to rehabilitate primary health care in Kandahar and Urozgan provinces reached to its end seeding propitious hopes for future harvest. It was a year that AHDS experienced financial uncertainty causing in shrinkage of services and cautiously proceeding. In spite of this AHDS could provide tremendous health services especially the mother and child health care in the areas where no other means were available.

Significant improvements in the year were introduction of two experienced female staff in management team of AHDS and training program for female staff. AHDS employed a female doctor as MCH coordinator and a female TBA master trainer to improve quality of mother and child health care in the region. Considering the Taliban's rigid policies its great to be able to provide training workshops in Kandahar Province for female health service providers of AHDS and other organizations working in the region.

AHDS found itself tough enough to propel in the hard situation faced in year 1999. But it was learning a hard way to never rely on one donor. Multiple donors should be sought for the future projects to eliminate possibility of facing to blind paths. The already built community based primary health care program in target area is extremely invaluable to be stopped by just the simple words "please wait for approval of budget" or "the priority is changed".

# AHDS' HEALTH FACILITIES

| No. | PROVINCE | DISTRICT | VILLAGE | HEALTH FACILITY |
|---|---|---|---|---|
| 1 | Kandahar | Arghandab | District Center | Mother and Child/Comprehensive Health Center (MCH/CHC) |
| 2 | | Arghistan | District Center | Mother and Child/Comprehensive Health Center (MCH/CHC) |
| 3 | | | Sundorzay | Basic Health Post (BHP) |
| 4 | | | Yousuf Khail | Basic Health Post (BHP) |
| 5 | | City | Loiwiala | Mother and Child Health center (MCH) |
| 6 | | | Kabul Shah | Regional Training Center (RTC) |
| 7 | | Daman | District Center | Mother and Child/Comprehensive Health Center (MCH/CHC) |
| 8 | | | Jakan | Basic Health Post (BHP) |
| 9 | | Dand | District Center | Mother and Child/Comprehensive Health Center (MCH/CHC) |
| 10 | | Khakrez | Chinar | Basic Health Post (BHP) |
| 11 | | | District Center | Basic Health Center (BHC) |
| 12 | | | Lam | Basic Health Post (BHP) |
| 13 | | | Nasir | Basic Health Post (BHP) |
| 14 | | Maywand | District Center | Mother and Child/Comprehensive Health Center (MCH/CHC) |
| 15 | | Panjwaie | District Center | Mother and Child/Comprehensive Health Center (MCH/CHC) |
| 16 | | Shahwalikote | District Center | Basic Health Center (BHC) |
| 17 | | | Kajoor | Basic Health Post (BHP) |
| 18 | | | Khairtoot | Basic Health Post (BHP) |
| 19 | | | Kundelan | Basic Health Post (BHP) |
| 20 | | | Lwala Wiala | Basic Health Post (BHP) |
| 21 | | | Paryan | Basic Health Post (BHP) |
| 22 | | | Suzni Achekzay | Basic Health Post (BHP) |
| 23 | | | Wayand | Mother and Child/Comprehensive Health Center (MCH/CHC) |
| 24 | Urozgan | Deh Rawood | Baghal | Basic Health Post (BHP) |
| 25 | | | Dehzak | Basic Health Post (BHP) |
| 26 | | | District Center | Mother and Child/Comprehensive Health Center (MCH/CHC) |
| 27 | | | Kakrak | Basic Health Post (BHP) |
| 28 | | | Labolan | Basic Health Post (BHP) |
| 29 | | | Miandow | Basic Health Post (BHP) |
| 30 | | | Segzai | Basic Health Post (BHP) |
| 31 | | Tirinkote | Garmab | Basic Health Post (BHP) |
| 32 | | | Kakrak | Basic Health Post (BHP) |
| 33 | | | Kali Kala | Basic Health Post (BHP) |
| 34 | | | Kala Now | Basic Health Post (BHP) |
| 35 | | | Sufian | Basic Health Post (BHP) |
| 36 | | | Surmorghab | Basic Health Post (BHP) |
| 37 | | | Town | Mohter & Child Health center (MCH) |
| 38 | | | Town | Comprehensive Health Center (CHC) |

*AHDS entreats you to participate in the process of peace for the indigent people who have lost their wealth and health by dedicating your time, empathy, advocacy and monetary inputs.*


**Main office:**

House 178
3rd Ghizali Road
D1, Phase 1
Hayat Abad
Peshawar, Pakistan

Phone: 092-91-817342

Tele-Fax: 092-91-810599

E-mail: ahds@brain.net.pk

**U.S.A. office:**

8133 Leesburg Pike, Suite 310
Vienna, VA 22182, U.S.A.

Phone: (703) 848-0407

Fax: (703) 848-0408

**Regional office:**

Opposite Sarwar-e Kayenat Mosque
Kabul Shah
Kandahar City
Kandahar Afghanistan

Phone: 93-3-210422

**Field office:**

Tirinkote City Urozgan
Afghanistan

**Mailing address:**

GPO Box: 631
Peshawar, Pakistan


**Account Number:**

1131435744090
ANZ Grindlays Bank
Shahrah-e-Qaid-e-Azam
Peshawar, Pakistan