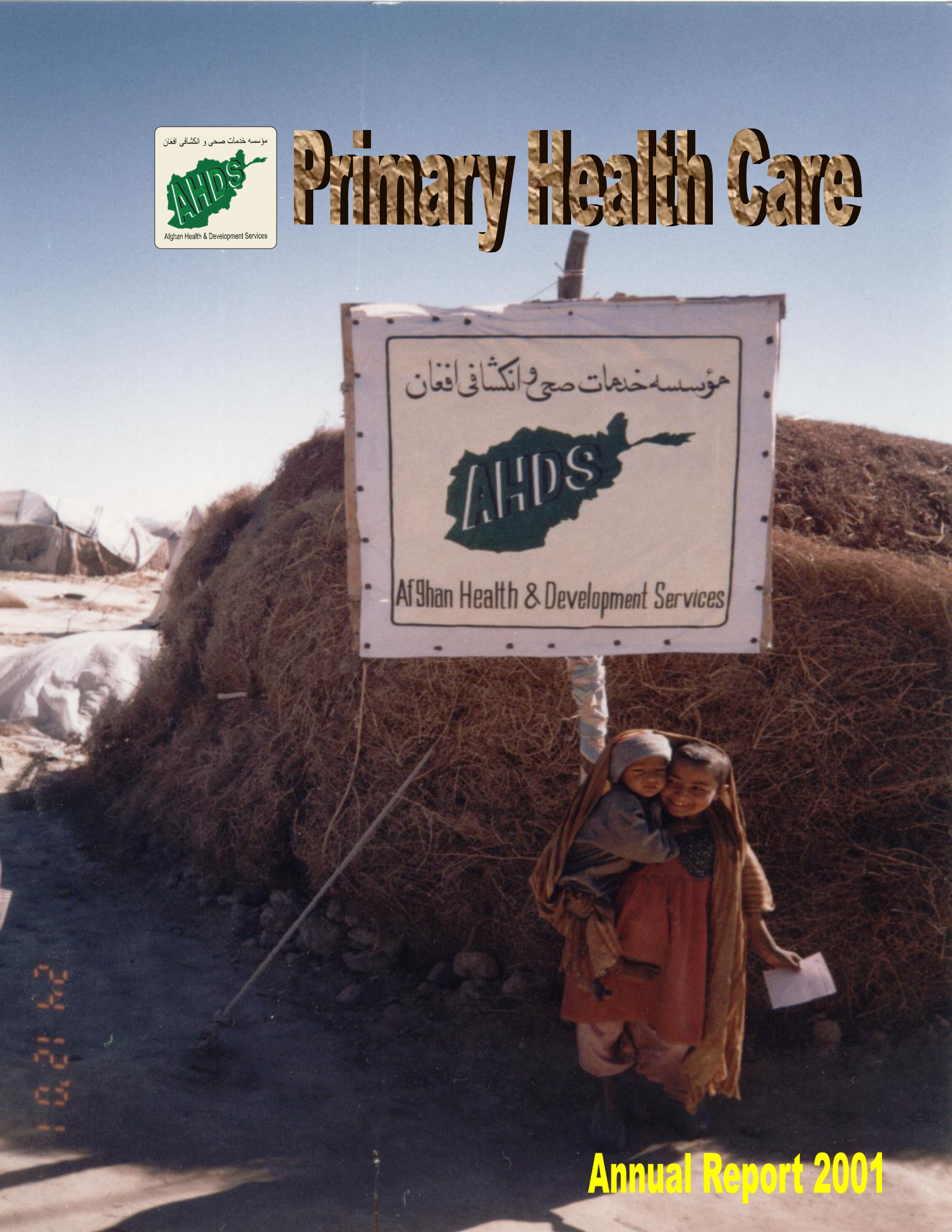
مؤسسه خدمات صحی و انکشافی افغان

AHDS

Afghan Health & Development Services

Primary Health Care



Annual Report 2001

Special thanks are due to:

Contents

Director's Remarks

Afghanistan's endless and intolerable burden of natural and man-made calamities continues to tax the Afghan people. Four years of drought and the ongoing internal conflict forced an estimated seven million people to leave their homes in search of water, food, security and other basic needs in the year 2001.

The unfortunate incidence of September 11, which shocked the entire world, resulted in the US led military operation in Afghanistan. Inevitably, the heavy bombardment has taken an additional toll on the innocent people.

The establishment of an interim government in Afghanistan has given a lot of hope to the millions of Afghans who are fed up with war, insecurity, poverty, lack of basic necessities, and the violation of human rights.

As the nation enters a new phase and the conflict unwinds, Afghanistan is faced with the enormous task of nation rebuilding, especially in light of the sheer magnitude of destruction, poverty, and human suffering.

Considering the international community's intensified and renewed concentration on the rehabilitation of Afghanistan, there is need for a concerted and well thought out plan for reconstruction. Even though rapid changes are taking place in the country, we must act with caution and plan with foresight, so that hasty decisions now do not hinder our progress in the long run. Careful situation analysis, building on existing blocks, stepping carefully towards valid indicators, evaluating resources, precise base-line surveys, realistic planning, on-time preparation, flexible strategic approaches, concise conclusions and keeping the cultural values of the country in mind are all keys to ensuring that our dreams for Afghanistan's tomorrow becomes a reality. In addition, dramatic changes should focus on reverting humane attitudes and behaviors rather than physical structures. The communities should be enabled to find their selves. Self-realization will be the key for self-determination and self-reliance of the Afghan communities.

Since conflict prevention cuts across all issues concerning the reconstruction of Afghanistan and is an essential part of the process of nation rebuilding, it is imperative to offer mechanisms to alleviate the peoples suffering in order to prevent the recurrences of conflict.

In the midst of all these miseries, disturbances, uncertainties, and insecurity I am proud to acknowledge that AHDS' dedicated health providers and the management teams of both field and main offices brought to realization AHDS' objective of serving the vulnerable children and women of Afghanistan in their most difficult time. I would like to extend my heart-felt gratitude for their dedication, perseverance and commitment.

On behalf of the beneficiaries and the AHDS staff I would like to thank all of our donors, partners, and the communities who have supported our efforts. It was their financial

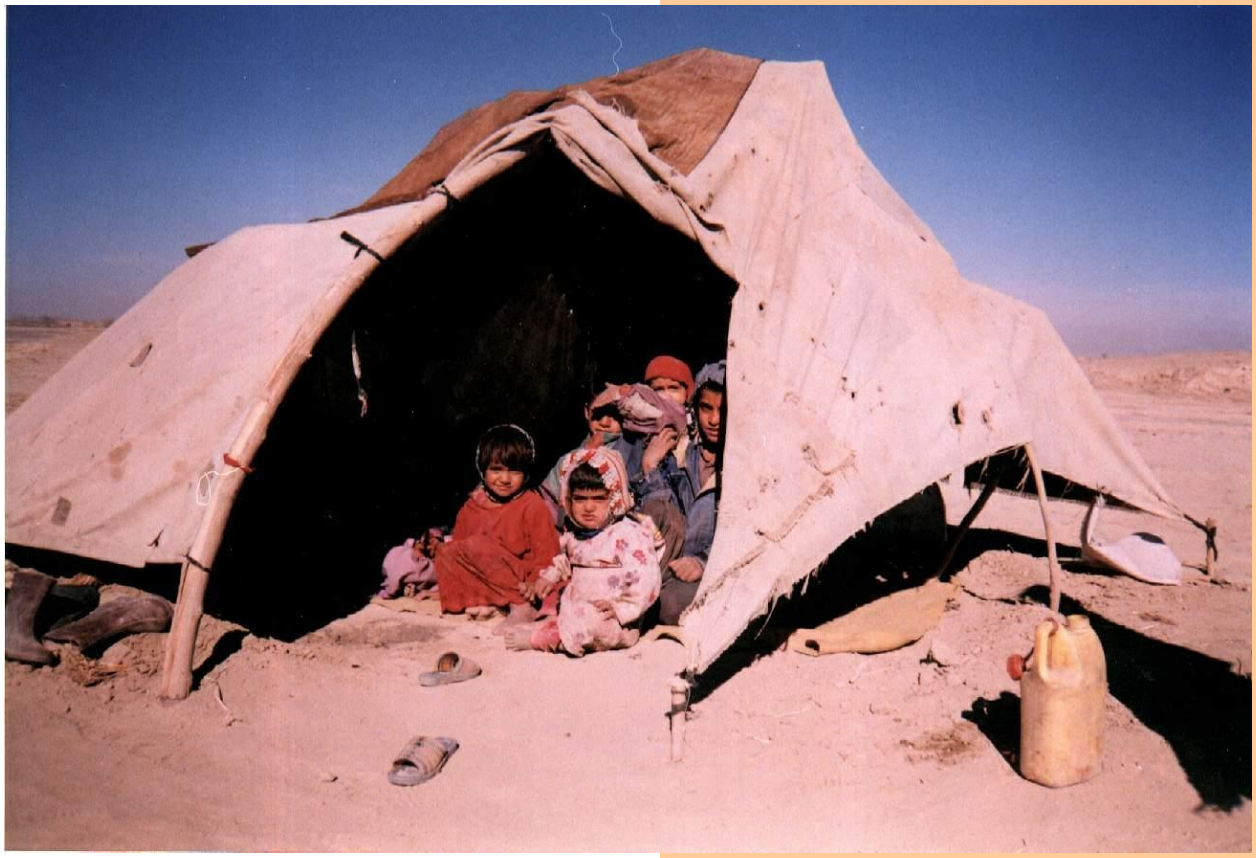
commitment, technical support, and collaboration that made our programs possible.

As the main financial supporter of AHDS, Bill & Melinda Gates Foundation has played a crucial role in the success of our programs for the last two years. We owe a tremendous amount of appreciation for their support and generosity.

Special thanks are due to Stichting Vluchteling (SV) and the United Nations Children's Fund (UNICEF) for their support of our water and sanitation program in the Urozgan Province.

We are optimistic that with the recent changes in Afghanistan, brighter days are in store for the Afghan people who have grown exhausted from more than 23 years of war, internal conflicts, natural disaster and instability. We are confident that AHDS' commitment to serving the vulnerable people of Afghanistan and facilitating a healthy civil society will play a crucial role in this historic juncture.

Aziz R. Qarghah
Director



Lessons Learned

The last two decades of war and instability in Afghanistan has made the role of international and national NGO's a crucial element in the rehabilitation and reconstruction of the country. The services provided by non-governmental organizations, such as AHDS, have made a positive contribution in the lives of the most vulnerable segments of the society (i.e. women and children).

Due to the latest political changes, such as the unfortunate occurrences of September 11, 2001, NGOs, donors and the international community foresees a new phase in which they must undertake serious alterations in their perceptions and judgments in terms of the community's needs, demands, and approaches. Longer- term developmental projects, closer cooperation and unified approaches between stakeholders will become essential in the future rehabilitation and development of the country. Integrated approaches in sectors such as health-care, education, irrigation, agricultural, veterinary and housing projects must be designed with the input of the local communities and their real needs in mind.

All projects must assume supportive approaches to the communities in order to enable them to determine their needs and contribute in the implementation processes. Transparency and accountability must be seriously observed and community Shura's or committees should be informed about the objectives of the projects and the relevant indicators and outcomes.

Some of the main issues that must be taken into consideration by NGO's in this new phase are:

- Short term and long- term strategies for intervention must be developed.
- The great gender imbalance should be corrected.
- Multi-sectoral approaches should be considered.
- There must be direct and open communication between all stakeholders.
- Psychosocial need of the population should be strongly addressed.

In the light of the recent positive developments in the country, especially on the political ground, AHDS enters a new phase in its history of serving the people. Therefore, we must prioritize our objectives, enhance the quality of services, and expand our target area in order to reach the underserved communities.

Our Vision

To promote the Afghan's civil society to the level of self-determination and self-reliance

AHDS Policies

1. Development/Rehabilitation of satisfactory base for social services
2. Equitable service to all Afghan communities on an equitable basis regardless of gender, ethnic, religious, and political affiliations
3. Focus on women and children the most vulnerable part of community
4. Community based set-up for sustainable social and developmental services
5. Affordability and effectiveness considering the poor socioeconomic infrastructure of Afghanistan
6. Decentralized system to target the most deprived, vulnerable and remote communities through full participatory approach
7. Integrated approach to provide comprehensive health and social services

Target Areas:

Location	**Population**
Kandahar	
Arghandab	80516
Arghistan	31894
Kandahar City	445486
Daman	30626
Dand	149943
Khakrez	21136
Maywand	66826
Panjwaie	119952
Shahwalikote	65990
Urozgan:	
Deh Rawood	66031
Tirinkote	69793
	1,148,193

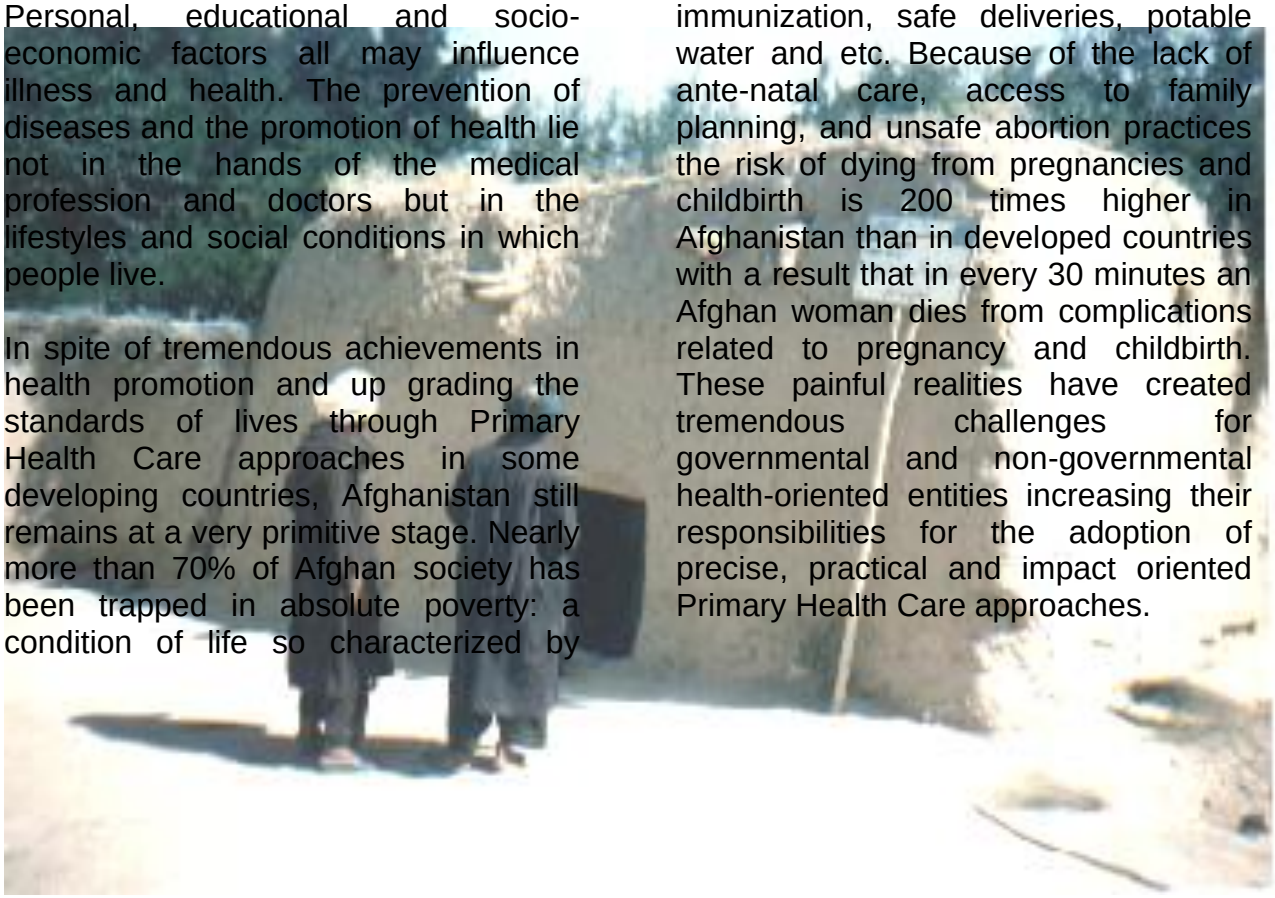
Primary Health Care, a key for development

While primary health care (PHC) strategies to achieve the aim of health for all was adopted by the Afghan Interim Government with collaboration with the World Health Organization in the early nineties, constraints in implementation continued to be a hurdle, particularly in the enhancement of community participation. Presently there is increasing recognition that socio-economic and cultural factors are prime determinants of health and health care.

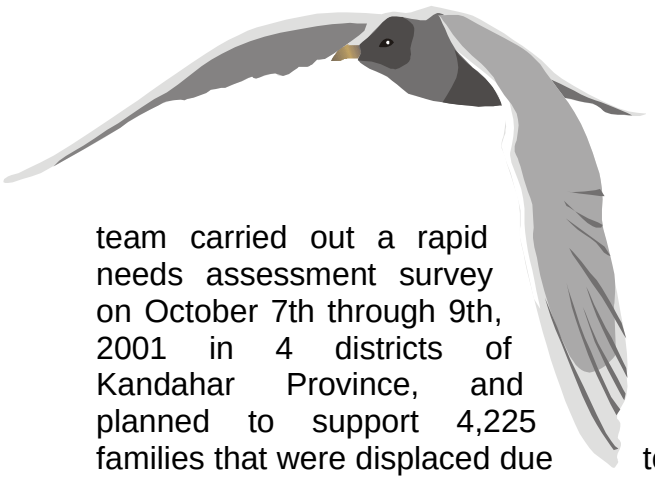
It is important to emphasize that understanding and studying culture in its context usually implies trying to discover how people view their own situation and how they solve their problems. Personal, educational and socio-economic factors all may influence illness and health. The prevention of diseases and the promotion of health lie not in the hands of the medical profession and doctors but in the lifestyles and social conditions in which people live.

In spite of tremendous achievements in health promotion and up grading the standards of lives through Primary Health Care approaches in some developing countries, Afghanistan still remains at a very primitive stage. Nearly more than 70% of Afghan society has been trapped in absolute poverty: a condition of life so characterized by malnutrition, illiteracy, disease, squalid surroundings, high infant mortality and low life expectancy as to be beneath any reasonable definition of human decency. While our neighboring countries are changing their focus from quantitative to qualitative health-care and moving towards enhancing their living conditions, we are at the beginning stages of this long journey to a healthy and prosperous society.

Of Afghanistan's estimated 26 million population, with two thirds being women and children, 4 % are disabled, 7 million are suffering from the effects of 4 years of continuous drought, and over 40% of the population does not have access to minimum health care measures like immunization, safe deliveries, potable water and etc. Because of the lack of ante-natal care, access to family planning, and unsafe abortion practices the risk of dying from pregnancies and childbirth is 200 times higher in Afghanistan than in developed countries with a result that in every 30 minutes an Afghan woman dies from complications related to pregnancy and childbirth. These painful realities have created tremendous challenges for governmental and non-governmental health-oriented entities increasing their responsibilities for the adoption of precise, practical and impact oriented Primary Health Care approaches.



Where we are?



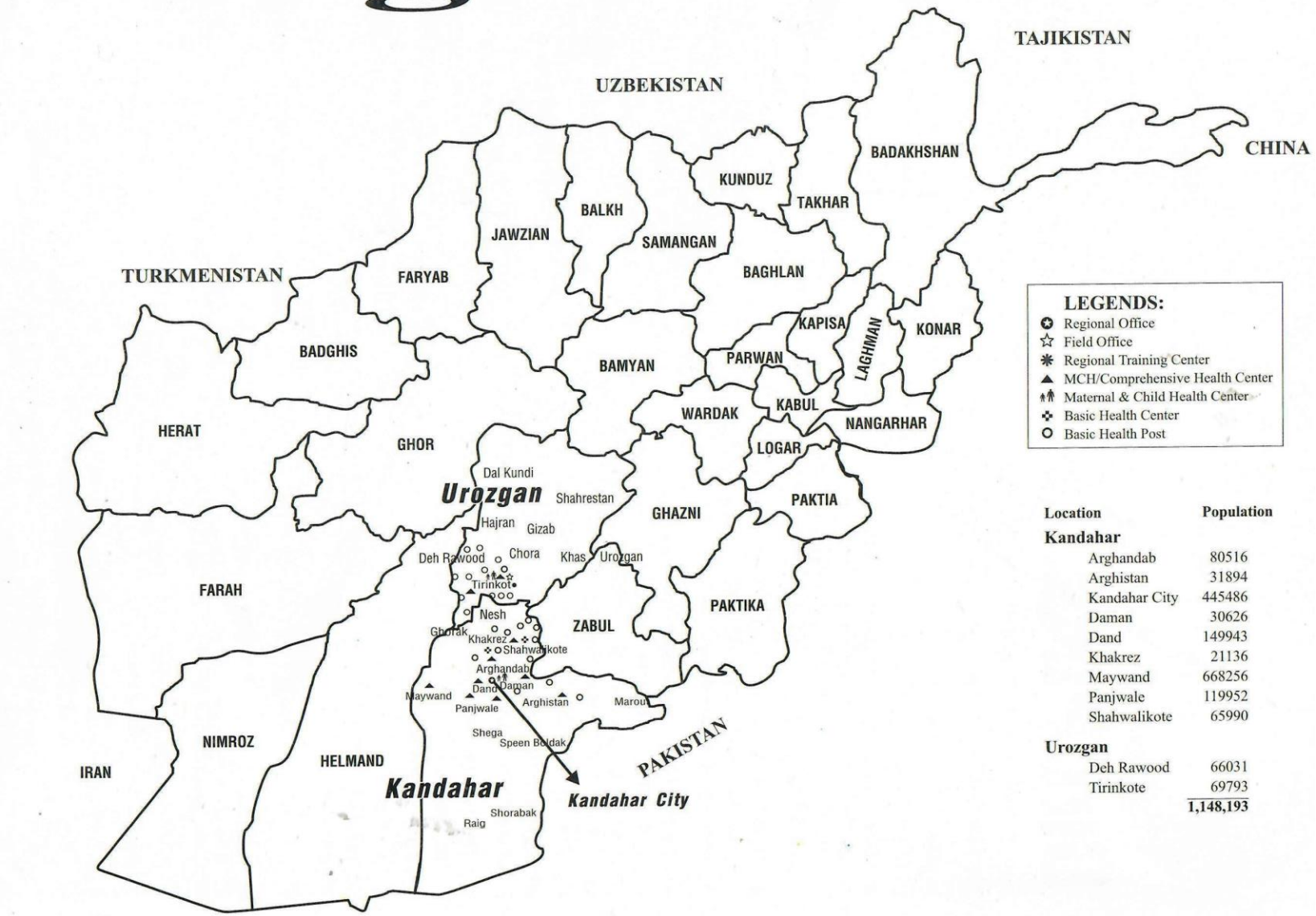
Integration of mother and child health services, immunization, water and sanitation and health and nutrition education in our comprehensive PHC program provided the opportunity to cover various health needs of the communities and increase the coverage. In all of our district health facilities immunization services for target children and women are available. This is an opportunity to increase and boost up routine immunization coverage in the target areas.

For the fourth consecutive year, the drought was a prominent constraint. Thousands of families were displaced from drought-affected areas to other villages in the region. Also, this year, the war brought with it another obstacle in the delivery of health services to our target communities, especially in the Kandahar Province where most of our activities are located. Despite the tremendous difficulties, the US bombings, and in the face of danger to their own lives our dedicated field staff bravely continued to provide needed medical services and kept all of our operations functional in the region. It is dedication like this that will be the foundation of the reconstruction of Afghanistan and is truly deserving of appreciation.

Considering the urgent evacuation of almost all aid agencies, our regional team carried out a rapid needs assessment survey on October 7th through 9th, 2001 in 4 districts of Kandahar Province, and planned to support 4,225 families that were displaced due to the critical situation.

All the health facilities were fully operational according to predetermined action-plan. Training opportunity for the local health service providers, health education for community members, polio eradication campaigns, vaccination against six killing diseases of childhood, emergency obstetric care, safe motherhood initiatives, treatment of common diseases and control of locally endemic diseases were accomplished in satisfactory manner to the target communities. In addition, the ad hoc clinic regularly serves internally displaced people (IDP) due to drought in an IDP camp. Upgrading of a MCH center in Kandahar City by establishing its maternity home, which is 24 hours in disposal of nearby and referred pregnant women, is a great achievement this year. Provision of Health Education Manual in two national languages (Dari and Pashtu) is provided and published for first time by AHDS.

Target Areas



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Our Pledges for the year 2001 were:

- To improve the health status of people living in the target areas
- To reduce infant, child and maternal mortality
- To improve capacity of Afghan human resources

Out Puts

AHDS is proud to report that a total of 684,991 individuals received benefits from its health services in the year 2001.

- 8,943 children are screened for malnutrition and received appropriate care.
- 624 sessions of food demonstration and health education for at risk children and mothers have been conducted (13,248 children were fed during these exercises).
- 1,000 copies of calendars and 16,000 copies of posters containing health messages were disseminated.
- 30,384 Health education sessions focusing on common health problems held for improving hygiene and healthy practices of the communities (reached a total of 445,758 individuals).
- 207,105 Vaccine shots were administered from EPI fixed centers and outreach.
- 162,110 Vaccine shots were administered to the target children against six fatal childhood diseases.
- 15,073 Child Bearing Age (CBA) women received TT2+ (second dose of tetanus vaccine).
- 349,686 Patients were treated in the health facilities.
- 134,594 Children (less than 15 years) received curative health services.
- 132,646 Women suffered from various diseases received appropriate treatment.
- 11,799 Pregnant women received antenatal care and pregnancy related illnesses treatment.
- 36,336 Lactating mothers received health services, child spacing consultation and child rearing related simple messages.
- 871 couple followed family planning regularly.
- 21,132 people participated in family planning awareness sessions.
- 970 Trained traditional birth attendants had visited 6370 pregnant women at their homes, assisted 4,137 deliveries and referred 260 cases to MCH centers.
- 300 Shallow wells (204 with hand pump and 96 without) and 525 sanitary latrines were provided to the communities.
- 492 staff (in 41 courses) received training in AHDS' Regional Training Center as well as 62 staff in other institutions.
- More than 2,100 Internally displaced families mainly affected by drought received basic health services (1,222 children vaccinated against measles, 5,127 clients received health education and 7,760 patients were treated), and non-food items (2,100 blankets, 6,500 sweaters, and 2,200 jerry-cans.) through our mobile health teams.
- 37 Health facilities were functional: at district level 8 Mother and Child Comprehensive Health Centers, 2 Mother and Child Health centers, 1 Comprehensive Health Center and 2 Basic Health Centers, and at village level 24 Basic Health Posts.
- Community contribution was US$ 57,177 (in kind and cash) for PHC program including water and sanitation.

Our Strengths

- Principally working in remote areas for the least developed communities.
- Highly motivated staff with strong commitment and sense of responsibility.
- Decentralized planning and decision- making procedures.
- Well-organized activities, timely intervention and decision-making.
- Close and consistent consultation between top-level managers and field workers.
- Continuation of activities during war and conflict situation (especially during US led air strike while almost all aid agencies fled the area).
- Community involvement and support.
- Accountability and transparency of works.
- Close coordination and cooperation with other partner agencies.

Jas van Mierlo, Program Officer Central Asia NOVIB, during visit our Water and Sanitation project.

Jean Francois Cautain, Afghanistan Program Coordinator of European Commission, during visit of our Primary Health Care program

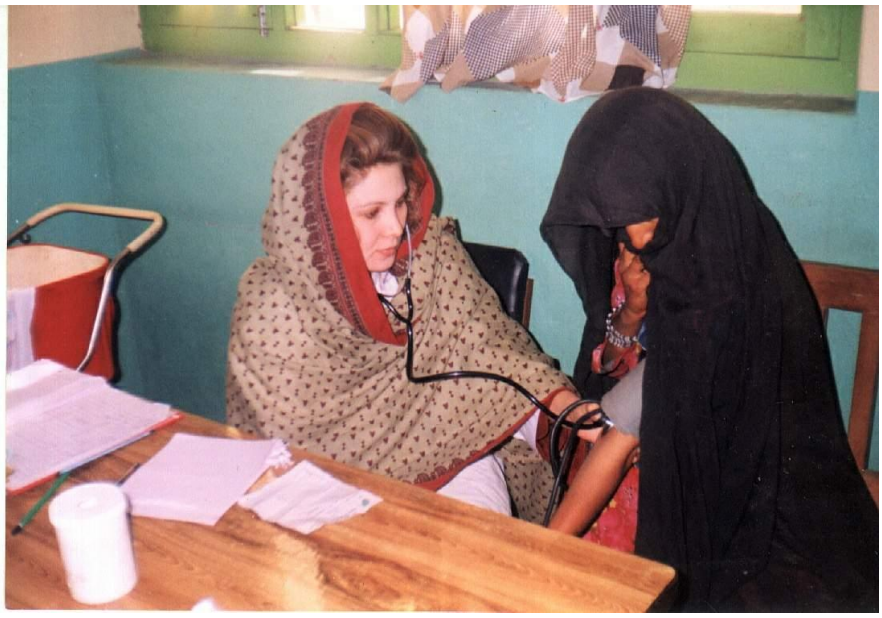
Reproductive Health

Reproductive Health (RH) is a main concern of AHDS' Primary Health Care (PHC) program. It is an important intervention for overcoming Afghanistan's basic health problems, especially those of the female population such as complications of pregnancy and delivery, infectious diseases, malnutrition and mental disorders. The aim is to reduce the high rate of maternal mortality ((1700/100,000) and morbidities related to pregnancy and delivery among women of 15-45 years of age.

Women and children, who were deprived of basic human rights in the society, are the most vulnerable groups affected by the consequences of two decades devastating war in Afghanistan. Our women and children suffer from tremendous physical and mental disorders in remote and underserved areas where they do not have access to basic and essential health care services. The tragedy of September 11 and the consequences for Afghanistan have enhanced the severity of the above-mentioned problems.

Objectives

- To reduce maternal and newborn mortality through promoted safe motherhood initiatives and emergency obstetric care.
- To provide family planning services within the context of women's reproductive health services and to ensure reasonable births spacing.
- To reduce the incidences of vaccine-preventable diseases through increased immunization and health education coverage.
- To continue capacity building activities to upgrade the skills of new health workers as well as the existing technical staff in order to improve the quality of services.



Our MCH centers are the only health providers for the rural areas of Kandahar and Uruzgan provinces and offer Reproductive Health Services, 7 days a week, 24 hours a day to the target population.

To achieve the objective of reproductive health we need the:

Principles

- Advocacy for women's rights
- Integrated services
- Quality assurance of services
- Capacity building
- Community involvement
- Coordination with authorities and other health NGOs

Activities

- Emergency obstetric care
- Safe mother hood initiatives
- Family planning
- Health education
- Immunization
- Early diagnosis and treatment of common diseases

Emergency Obstetric Care

Deliveries:

In order to prevent excessive neonatal and maternal morbidity and mortality and to promote clean deliveries, AHDS has provided clean delivery kits for female health staff inside health facilities and for TBAs to use them in the villages.

A total number of 4,600 normal deliveries (463 inside the health facilities and 4,137 home deliveries by TBAs) have been assisted during year 2001. The number of reported deliveries assisted by TBAs compared to the last year shows some deduction, which could be the results of security problem during the last quarter of this year, in terms of limitations in collecting reports.

Care of the new born babies consisting of cleaning the airway of the newborn, keeping the baby warm, providing eye and cord care, helping mothers breast feed and identifying the complications that require referral services. No maternal and neonatal mortality or stillbirths are reported during year 2001.

Complicated cases:

A total of 59 abnormal deliveries, including abnormal presentations, twin deliveries, deliveries by women over 35 years of age, women with history of complicated deliveries or other at-risk mothers referred by TBAs or after antenatal care were assisted in our MCH centers.

519 cases of abortion (mostly threatened) are reported during the year 2001. These patients have received treatment and emergency care inside our health facilities. AHDS does not have the luxury of transportation and other facilities for a continuous follow up system; therefore, we were not able to record the exact number of post abortion or delivery mortality or morbidity rates among women.

Safe Motherhood initiatives

Safe motherhood includes antenatal, delivery and postnatal care aimed at reducing the high numbers of deaths due to pregnancy and childbirth related illnesses among women, and to address the direct medical causes and undertake relevant activities.
It is estimated that approximately 13% of pregnant women will develop complications that require essential obstetric care, and up to 5% of pregnant women will require some type of surgery.

Antenatal care:

In order to establish contact with pregnant women, assess maternal health, identify and manage current and potential pregnancy related risks and problems at least two antenatal visits are recommended. Women living in remote areas are usually not easily willing to visit health facilities unless they feel a major health problem. Creating opportunities to share any kind of health-related problems could be the main reason of our success in attracting women for follow-up of antenatal visits in our health facilities.

A total of 6,437 antenatal-visits for different purposes have been recorded during year 2001. 2,799 women with common problems of pregnancy, mainly low back pain, hypertension, peptic diseases, anemia and related complaints, have been treated in the MCH centers.

56 cases of toxemia of pregnancy were diagnosed and treated in the MCH centers. The possible reasons for hypertension and pregnancy toxemia are fatty diet, crowded families and the psychological stress on women. Due to regular antenatal care of pregnant mothers by trained TBAs in the villages and midwives inside health facilities the number of toxemias of pregnancy cases has gone done by half, since last year.

Postnatal care:

The postnatal visits provide an opportunity for assessing and discussing issues of hygiene, care of the newborn, breastfeeding and appropriate methods and timing of family planning. Since 50% 0f maternal deaths occur

Role of TBAs in EOC:

A total of 970 traditional birth attendants (TBAs) are trained (30 during year 2001) to assist home deliveries by identifying risk factors, providing immediate advice, and the knowledge of when and where to refer a complicated case for advanced care. 6,370 home visits have been performed by the TBAs for ante/post-natal care.

260 women, including at risk pregnant mothers and other cases that required surgery or skilled assistance were referred by TBAs to proper healthcare facilities. TBA trainers according to the action plan of the female TAB Master Trainer performed regular supervision and re-supply of the TBAs.

The main complications of home deliveries without assistance of a trained TBA according to our experiences are retention of placenta. These cases have decreased since our trained TBAs are assisting in more home deliveries.

after delivery, possibly in the first and second day, (Reproductive health manual-UNFPA), our health workers and trained TBAs assess the mothers' general condition and recovery after childbirth (mostly within the first 24-48 hours) to identify any specific complication.

1,828 postnatal visits have been recorded in our MCH centers. The main postnatal complications reported among women who received treatment in AHDS MCH centers were hemorrhage, perineal trauma, uterine prolapse, anemia, breastfeeding problems like little milk or breast infections, and uro-genital infections.

Family Planning:

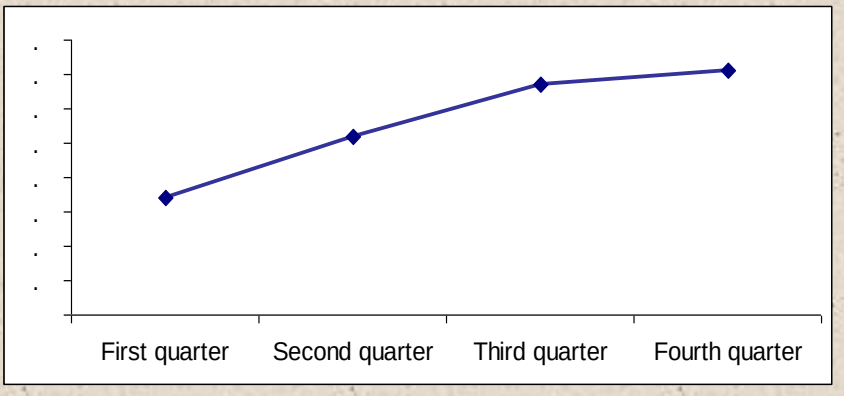
As a main objective of reproductive health, family planning directly insures the health of mothers and indirectly the health of the entire community. Our health workers and trained TBAs have launched tremendous efforts to encourage both men and women to use the safest contraception methods and improve community awareness through outreach and education sessions inside the clinics. For a safer live style, TBAs encourage women to keep at least 2-3 years' space between pregnancies, ensure planned pregnancies, and avoid pregnancies before reaching18 years of age and after 35 years' age.

Last year, 21,132 women received essential messages regarding the benefits of birth spacing and pregnancy related care. Contraceptive prevalence rate in our target areas has increased from 0.34 to 0.71. The estimated number of contraceptive users in AHDS health facilities during 2001 was 871 couples, which maintained family planning for at least one year.

According to our statistics the most popular forms of contraceptives were natural family planning, also called safe period (691), depot progesterone (733) and strips of contraceptive pills (1,828 strips). Other methods like condoms (377) are still not very popular.

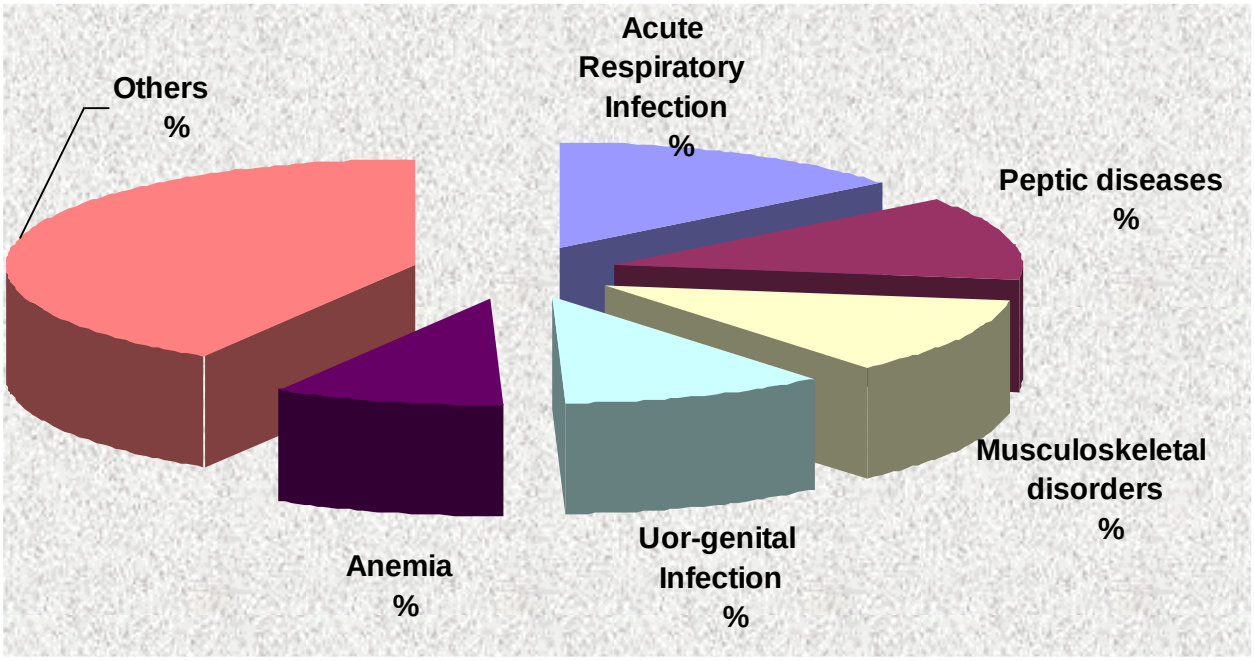
Women prefer to use those family planning methods that ensure their rights of confidentiality and privacy about their choices of the methods. But frequently men and mother in- laws are the decision makers in this regard. There is a great need for improving awareness in men to encourage them for taking an active role in the family planning decision-making process. Our male health educators provide basic information in this regard and try their best to convince the male population to accept certain family planning approaches.

Estimated contraceptive prevalence rate during year 2001



Treatment of Common Diseases

37.5% of the patients who received treatment in AHDS health facilities last year were women. This percentage shows a 1% decrease compared to the year 2000; which could be due to bad security and the critical situation during the last quarter of 2001. The cases were managed according to AHDS treatment protocols and MCH guidelines. MCH centers provided consultations with a minimum fee and provision of free essential medicines. Almost all MCH centers were equipped with 2-5 beds for emergency or other required in-patient services.



Top five diseases of women (AHDS clinics in year 2001)

Problems /Obstacles

The ongoing political instability in Afghanistan has affected proper implementation of our programs. Lack of basic human rights, the low level of decision-making role for women, the ban of formal education, and the restriction of movement for women, in addition to the difficulties which lie in providing qualified staff and training opportunity for female health workers, have contributed to the slow progress of Reproductive Health Care in Afghanistan. The last quarter of year 2001 was less productive due to the heavy US bombings in Afghanistan, and especially in the Kandahar Province. In spite of this painful situation, AHDS health facilities were fully functional until the end of November and were kept operational, with male staff, until the end of the year. Some of the related activities like the TBA training program, training of female staff and outreach health education stopped during the mentioned period.

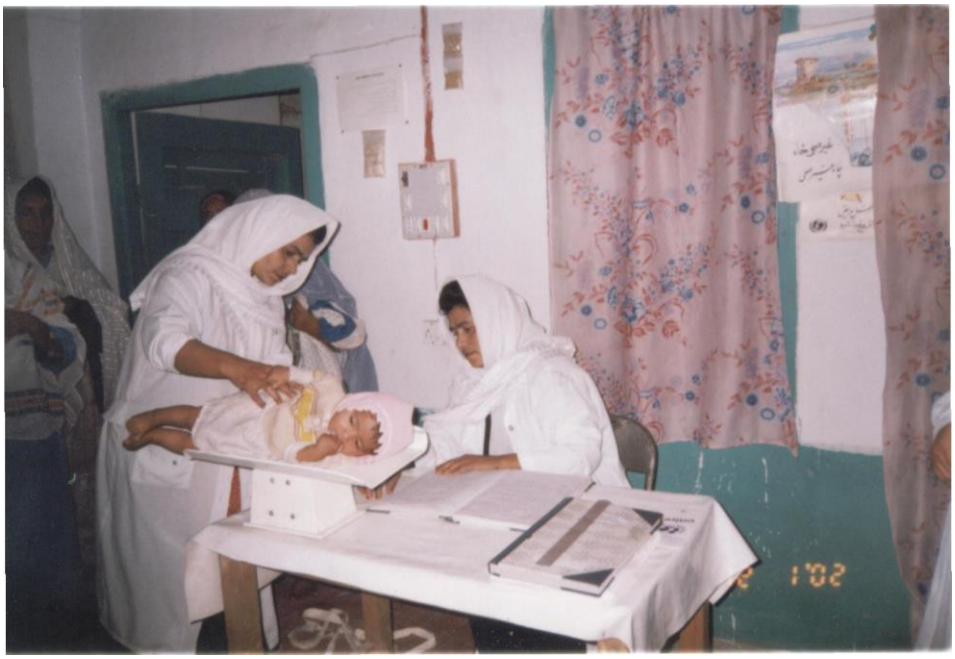
Childcare

Objective:

- Reduce infant and child morbidity and mortality through the continued focus on an integrated management of childhood illnesses and general health and nutrition education.

Provision of vaccination against 6 killer childhood diseases, consultation to the sick children with a minimum fee, free of charge essential medicine, growth monitoring and health education especially about acute respiratory infection, diarrheal diseases and nutrition are our main concerns. AHDS being main health provider in the area must play a proactive role in promotion of health status for children. An agreement is made between AHDS and UNICEF to start supplementary feeding program for malnourished children and pregnant and lactating women from January 2002.

Children made 38.5% of curative service beneficiaries in year 2001. The five most prevalent illnesses among children in Afghanistan, i.e. acute respiratory infection (ARI), diarrheal diseases, measles, malaria and malnutrition, were seriously taken care by AHDS health facilities. In addition, all other common diseases of children were treated. The statistics from AHDS health facilities show top five prevalent diseases among less than five years' children as follows; ARI (39%), diarrheal diseases (30%), malnutrition (7%), eye infections (5%) and skin disease (4.3%). Incidence of malnutrition is higher comparing to last year, which is effect of drought and lack of food security. Fortunately, number of measles and malaria was lower; 176 and 990 respectively.

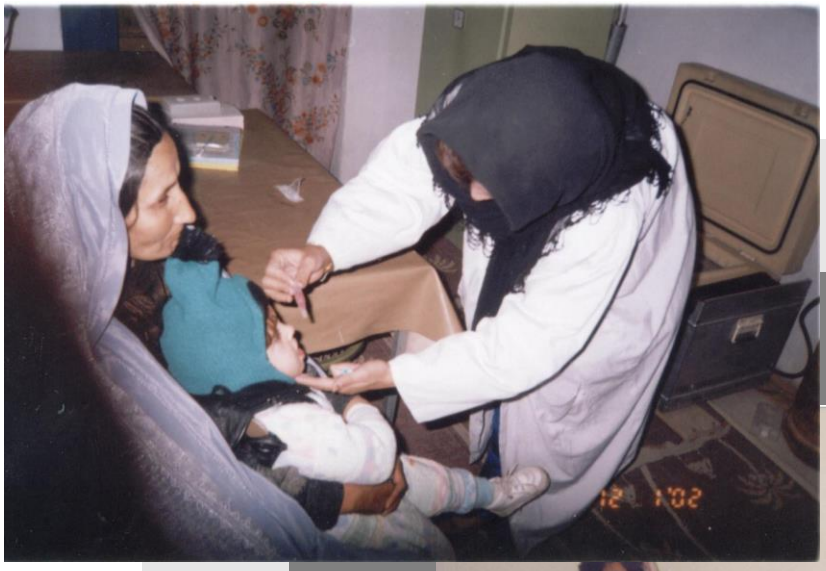


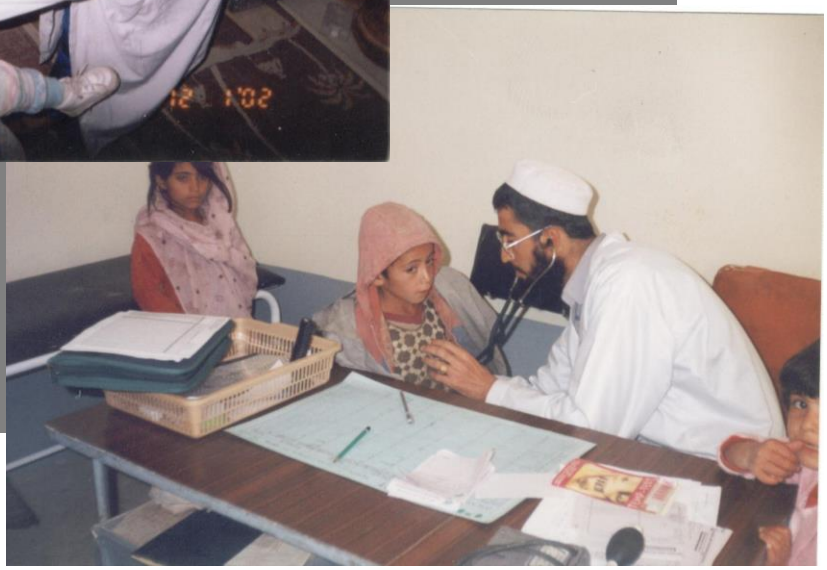
The following diseases targeted by expanded program of immunization (EPI) were recorded in AHDS health facilities during year 2001:

- Whooping cough (Pertussis) 690 cases
- Measles 304 cases
- Pulmonary tuberculosis 223 cases
- Diphtheria 5 cases
- Poliomyelitis 3 cases
- Tetanus 2 case

162,110 Vaccine shots were administered to the target children against six fatal childhood diseases. Polio eradication campaigns were very successful this year. In addition to the routine vaccination, AHDS with support of UNICEF and MSF Holland had mass immunization campaigns in different locations of Kandahar and Uruzgan provinces. Our mobile teams have managed 3 whooping cough and 11 measles outbreaks.

5,962 Malnourished children were recorded and taken care by AHDS health facilities. Food demonstrations (624 sessions), twice a week in MCH centers, have taught mothers the preparation of simple nutritious food for their children. 13,248 at risk children and mothers were fed during these exercises.





AHDS staff has walked village by village to eradicate Polio the enemy of our children

Immunization Coverage

Objective:

- Reduce the incidence of vaccine-preventable diseases through increased immunization and related health education coverage.

AHDS' 13 vaccination teams have administered 207,105 vaccine doses routinely to women and children of target area. In average 45% of less than one-year age children are immunized against the 6 killing diseases and 12% of childbearing age women are immunized against tetanus (TT2 coverage) in the catchments' areas.

UNICEF provides supplies, technical support and partial incentive for the vaccinators. Routinely, the he Expanded Program of Immunization (EPI) is carried out inside EPI fixed centers located in AHDS facilities and outside in the villages. In addition, NIDs, mopping up campaigns and mass immunization campaigns are also managed.

During the fall of 2001, in spite of the prevailing critical situation and the US air attacks, AHDS remained the main implementing body for the NID campaign.

As the main health sector implementing body in the region, AHDS contributed significantly in the 4 rounds of National Immunization Days (NIDs) campaigns for polio eradication. These NIDs were on March 15 –17 April 17 – 19, May 19-21, September 23-25 and November 7-9 (lead by MOPH, WHO and UNICEF). Its coverage was more than 100% in Kandahar and Uruzgan provinces. All children of less than five years received oral polio vaccine (OPV) and the children from 1 to 5 years' age received vitamin A.

Following a report of 3 cases of Polio a mopping up campaigns in 4 areas of Kandahar Province was launched in which 168,696 children received OPV (July 7th – 9th).

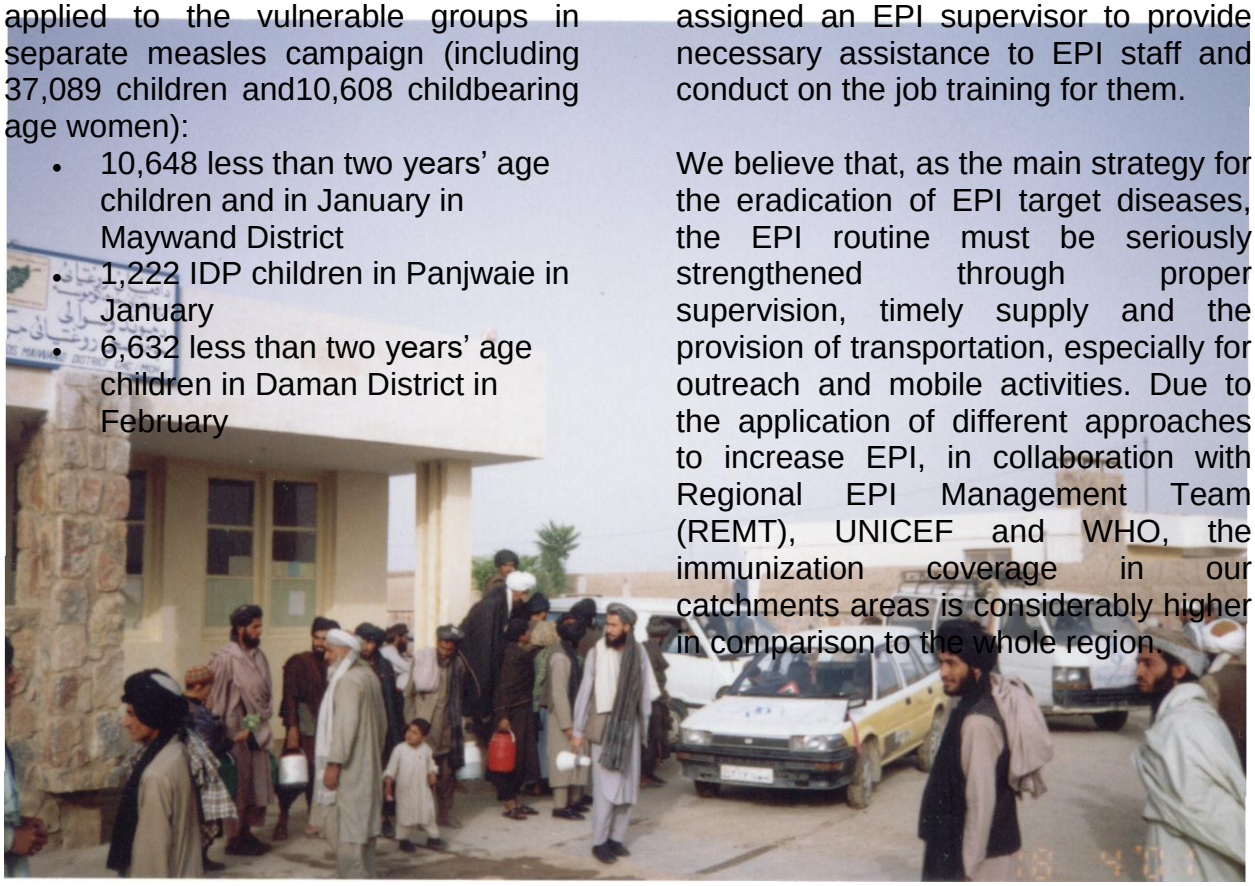
47,697 doses of measles vaccines were applied to the vulnerable groups in separate measles campaign (including 37,089 children and10,608 childbearing age women):

- 10,648 less than two years' age children and in January in Maywand District
- 1,222 IDP children in Panjwaie in January
- 6,632 less than two years' age children in Daman District in February
- 1,540 children in Deh Rawood in February
- 657 children in Shahwalikote in February
- 780 children in Arghistan in March
- 463 IDP children in Panjwaie in March
- 502 in Khas Urozgan in March
- 14,645 children during measles campaign in Arghandab in September – October

DPT campaign was done for 400 children in Mawand and Panjwiae for the IDP children.

We have female vaccinators with extra incentives in each of our MCH/CHC facilities as EPI fixed teams and assigned the male vaccinators for outreach activities. We have also assigned an EPI supervisor to provide necessary assistance to EPI staff and conduct on the job training for them.

We believe that, as the main strategy for the eradication of EPI target diseases, the EPI routine must be seriously strengthened through proper supervision, timely supply and the provision of transportation, especially for outreach and mobile activities. Due to the application of different approaches to increase EPI, in collaboration with Regional EPI Management Team (REMT), UNICEF and WHO, the immunization coverage in our catchments areas is considerably higher in comparison to the whole region.

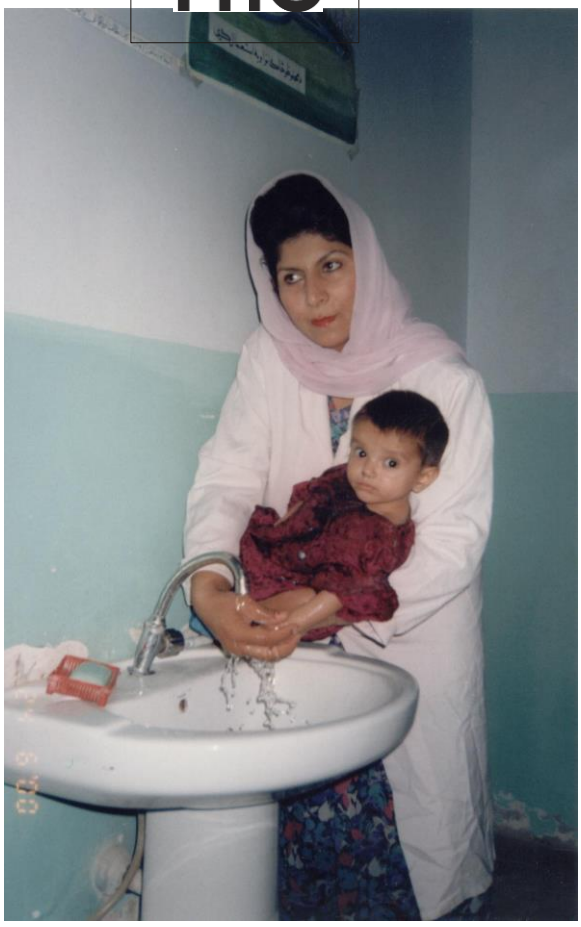


Health Education

Objective:
Improve community health knowledge and behavior through on-going community outreach health education.

Through 30,384 health education sessions we could encourage a total of 445,758 individuals to improve hygiene and healthy practices of the communities. MCH center managed 624 sessions of food demonstration and health education for at risk children and mothers have been conducted (13,248 children were fed during these exercises). Prime health messages were disseminated on 1,000 copies of calendars and 16,000 copies of posters. A health education manual in two Afghan national languages (Dari and Pashtu) was provided and published for the first time by AHDS. The book is made available to other NGOs and MOPH for usage as a health education learning aid in their projects.

As a general rule, rapid progress in the health status of the population can be obtained through close cooperation between patients, the public and the health providers. The approach of the health providers with the public, communities and the individual patients is extremely important in obtaining their trust to cooperate in their own treatment. In reaching this goal, a good advice to follow would be to work **with** the communities and not merely **for** them.



Our nurse demonstrates how to wash hands of a child using soap

Keeping cooperation in mind, we have been able to work with the communities and persuade them to take an active role in their status well-being and general health by:

- Recognizing the symptoms of diseases and risk factors quickly and coming for treatment and consultation.
- Listening to the advice of health professionals regarding healthy practices and following them carefully.
- Coming forward for preventive services like immunization, antenatal care etc.
- Choosing more nutritious foods and preparing them well.
- Seeking safe water and disease-free foods.
- Carefully disposing of wastes, especially human wastes that can lead to the spread of diseases. Using sanitary latrines.
- Caring for their children in a sound and hygienic way.
- Adopting a healthy and positive life style.

Because health is a reflection of our culture, it is imperative that health workers, especially health educators, be aware of the community's culture, beliefs, life style, perceptions, demands and needs. During health education sessions, the interest of the community is kept in mind, and an open atmosphere is fostered to allow for active discussion in order to avoid one-way communication that might lend to boredom and lack of interest on the community's part. In order to meet these challenges, AHDS has initiated field trips and house visits for its health education sessions so that a closer partnership is formed between the health educators and the local communities.

Main ill behaviors affecting health in the region:

Although health is an important issue for all human beings and everybody has different perceptions of his/her health, it is a common mistake that health is almost always interpreted in negative words; the absence of illnesses or sufferings. For the majority of our people health is the absence of pain. Pain is the only cause for referring to a doctor or whoever can be able to calm it.

Because the only signal of seeking a cure is pain, many diseases go unreported by the population until they are in their latest stages. Early signs, such as abnormal growth on shoulders (e.g. lipoma or sarcoma) are ignored if there is no pain associated with. In some cases, even after being informed that their condition is life threatening, they will not seek medical help until the pain becomes unbearable.

Furthermore, the endurance of pain itself is associated with bravery and sometimes sarcastic remarks are made to those who refer to health professionals for their ailments.

As a result, a part of patients who come to our health centers are usually in the latest stages of their disease and require special interventions that are sometimes beyond the functional capacity of the health centers. One of the main causes for such negative attitudes towards health care is the lack of accessibility to health education that still prevails in most of the country.

Restriction on women's mobility is one of the obstacles that have a cultural origin. Even women themselves say unfair words to those women who seek cures for themselves or their kids by visiting health centers. This is why, sometimes, kids are accompanied into health centers by another child who is neither able to provide information about his/her illness or understand the relevant consultation of the service provider.

In order to play a significant role in changing these values, attitudes and behaviors in the years to come, our health educators need to increase their contacts with the community leaders, elders, intellectuals and other influential members of the community and special sessions and demonstrations need to be tailored for the communities to increase their awareness of issues such as routine vaccinations for children, referring diseases to health centers in their early stages, using sanitary latrine, properly disposing excreta and other similar issues.

Channels of communication:

There has been a continuous, effort to explore effective communication methods between our health education section and the communities and the individuals. Our experience shows that the most effective, but limited, channels of communication in this regard are (a) group discussions that are focused on a specific health problem being considered in certain number of individuals or families, (b) demonstrations and rallies on specific occasions, for example while sanitation latrines or wells are built a demonstration consisting of elders, school teachers, and community members are arranged to teach the proper use of latrines and water wells, (c) disseminating printed materials like brochures and leaflets containing necessary information and key messages addressing certain health problems prevailing in the region, and (d) public gatherings on National Immunization Days (NIDs).

Social mobilization and Advocacy meetings:

Limited meetings and sessions have been offered in this regard. However, communities have been mobilized through meetings being organized with their representatives as members of community health committees. The representatives have discussed the communities' needs during the meetings, proper solutions have been found for the problems, and necessary advocacy meetings have been scheduled with the relevant authorities.

Diseases Prevalence

Objective:

- Provide basic curative services to the whole target population, including emergency inpatient services.

Socio-economic, seasonal and geographical conditions, which are the major determinants of health, have caused high incidences of life-threatening diseases such as serious communicable diseases, malnutrition, Gyno-Obstetric emergencies, and injuries due to mine explosion or war accidents in our catchments area.

AHDS treated 349,686 patients in year 2001through consultation, clinical laboratory services, dentistry and free of charge essential medicines. Case definitions and treatment protocols are standardized by the regional training center (RTC) for all AHDS' health facilities, which is updated annually. The essential drugs supplied are in accordance with these protocols in line with WHO essential drugs. In addition, 1,113 emergency obstetric cases and severe sick conditions were hospitalized in district health centers. Two health facilities are improved by addition of physiotherapy centers for disabled with support of Comprehensive Disabled Afghans' Program (CDAP) from UNDP. A considerable number of incidences of mine injuries and war accidents were attended to by our existing facilities directly or through referrals to the surgical wards of Mirwais Hospital and the Military Hospital in Kandahar City.

Top five diseases:

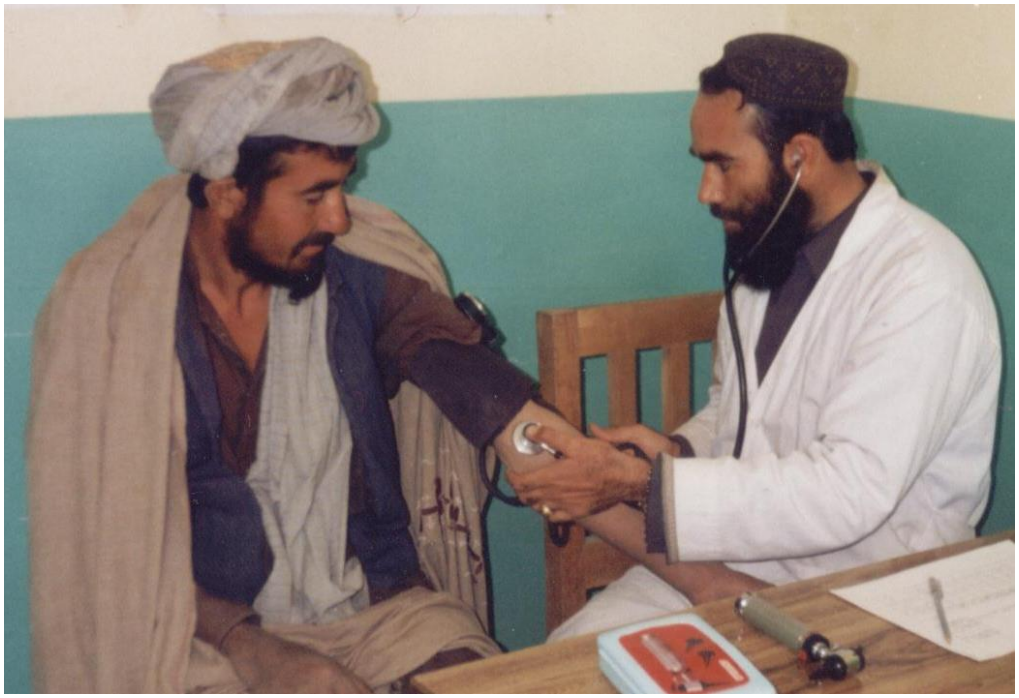
The following table shows most prevalent disease subsequently.

Children	Women	Men
Acute Respiratory Infection	Acute Respiratory Infection	Acute Respiratory Infection
Diarrheal Diseases	Peptic Diseases	Diarrheal Diseases
Malnutrition	Musculoskeletal Disorders	Peptic Diseases
Eye Infections	Anemia	Musculoskeletal Disorders
Skin Diseases	Urinary Tract Infections	Urinary Tract Infections

Seasonal prevalence of communicable diseases:

The high incidences of communicable diseases in the region may be due to low immunization coverage, limited accessibility to health services (underserved areas), lack of awareness and mal practices in term of interpretation of different health related values and lack - of environmental sanitation.

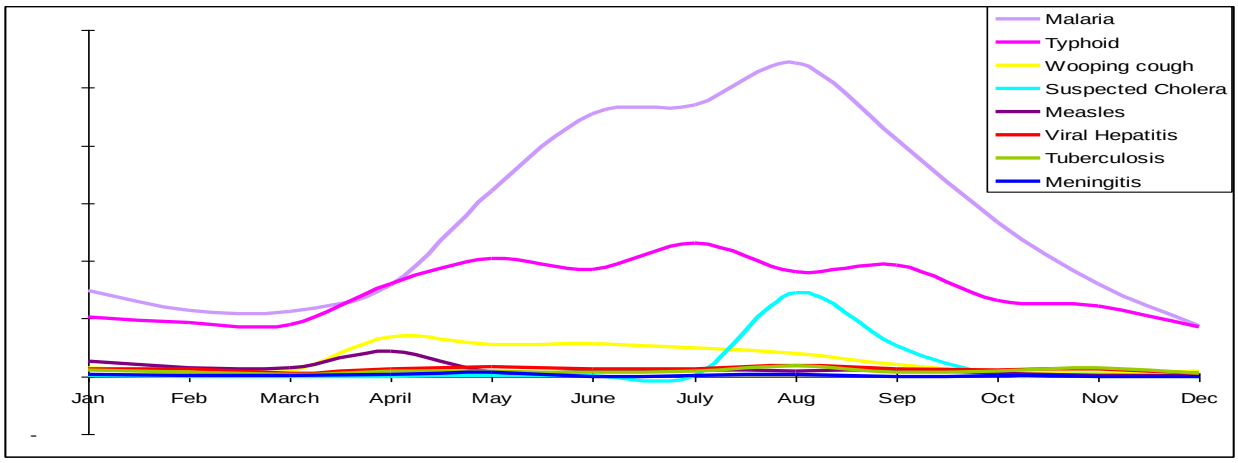
16,875 cases of acute bloody diarrhea, 3559 cases of typhoid fever and 416 cases of suspected Cholera with 6 deaths were reported. Our teams could manage to restrict the outbreaks on time with support of MSF, UNICEF and WHO.



The outbreaks of measles and whooping cough were another misery, which were mentioned before under childcare.

Malaria is an endemic communicable disease in Kandahar and Urozgan provinces. 6,491 cases were treated with support of Health Net International's (HNI), which was 20% less than last year. Role of health education and distribution of drug impregnated bed nets are appreciable.

Outbreaks of whooping cough (690 cases) and measles (304 cases) also threatened lives of children. Viral hepatitis mainly type A (293 cases) had bit higher incidence among men. Comparatively limited number of tuberculosis (223 cases) and meningitis (39 cases) are recorded in our health facilities.



Monthly trend of communicable diseases reported from AHDS' health facilities in year 2001

Capacity Building

Objective:

- Continue to build the capacity (through training) of new health care workers and to upgrade the skills of current staff to provide quality health care services.

AHDS believes in capacity building of local human resources as the key point of sustainability for the PHC program in order to manage quality social services for their communities. AHDS' Regional Training Center (RTC), established in 1995, has been recognized as the main capacity building unit in the region. This center provides in-service, on the job and refresher training for AHDS staff and partner organizations like WHO, UNICEF, and MSF on issues such as primary health care management, water and sanitation, training of trainers (ToT) for health educators, nutrition, and seminars on up dated curative measures on certain health problems.

The Regional Training Center (RTC) has offered 34 workshop and seminars and 8 refresher courses in year 2001. Participants of these courses were 172 female and 320 male health providers mainly from AHDS and some from other organizations (totally 402 people).

In addition to the trainings in AHDS' RTC, the staff (62 people) were introduced to community based social development, health management and research, epidemiology and survey, health information system, reproductive health, clinical laboratory, office management and TOT for community mobilization to credible institutions: in Agha Khan University (Karachi), MRCA hospital (Peshawar), Abasyn Institute of Management Science (Peshawar) as well as MSF, HNI, UNICEF and WHO training courses.

Main activities of RTC carried out in 2001:

MONTH	TYPE OF TRAINING	DAYS	COURSES NUMBER	Participants		
				PROFESSION	#	
					M	F
Jan.	PHC workshop	2	2	Different health workers	10	10
	Pneumonia seminar	1	1	Basic health workers		12
	Village Health Volunteer training course	18	3	None		60
Feb.	BHW refresher course	6	2	Basic health workers		17
	Family Planning seminar	6	1	Different health workers	10	
	Urinary tract infection seminar	2	1	Different health workers	8	
	Typhoid seminar	1	1	Basic health workers		12
	Planning workshop	4	1	People involved in management		16
Mar.	TBA trainer refresher course	6	1	TBA trainers	8	
	Shock workshop	2	1	Doctors and Nurses	13	
	Hygiene/sanitation workshop	1	1	Basic health workers		11
Apr.	Administration workshop	3	1	Clerks/ registrars		8
	Pelvic inflammatory diseases seminar	2	1	Doctors	8	
	Skin infections seminar	2	1	Doctors and MLHW		14
	TBA training course	14	1	Traditional birth attendants	15	
	Control of diarrhea and cholera workshop	1	1	Basic health workers		12
May	Health education course	12	1	Health educators	8	
	Dental refresher course	6	1	Dental technicians		6
	Toxemia of pregnancy, seminar	2	1	Doctors	11	
	Family planning seminar	1	1	Basic health workers		12
Jun.	Health education workshop	10	1	Health educators		10
	Nursing refresher course	6	1	Nurses	6	
	Mental disorders workshop	2	1	Doctors	11	
	Control of diarrheal diseases workshop	2	1	District health officers and BHC in-charges		12
	Early warning system/emergency preparedness workshop	1	1	Doctors Nurses		26
	Malaria seminar	1	1	Basic health workers		12
Jul.	Refresher Course	6	1	Basic health workers		8
	Mental disorders	2	1	Doctors, Nurses		20
	CDD workshop	2	1	Health workers	10	
	HIS training course	5	1	Doctors, Nurses	13	
	TBA training course	18	1	Traditional birth attendants	15	
Aug.	Refresher Course	6	1	Lab Technicians		12
	Helminthic diseases	2	1	Doctors		10
	Malaria	2	1	Health workers	11	
	CDD	3	1	Health workers	15	
Sep	Refresher Course	6	1	Health educators		5
	Refresher Course	6	1	MLHW		6
Nov.	Nutrition	1	1	Basic health workers		9

Training Methodologies:

Besides the traditional teaching methodology of instructive lectures and question and answer sessions our training center also uses group discussions, presentations, brainstorm sessions, storytelling, demonstrations and field visits to facilitate for different learning styles. Although the participatory methodologies are not as widely used for such issues as PRA tools, field works, self-awareness exercises, gender awareness, home economics and nutrition, we would like to make this methodology more dominant in the years to come.

How courses are scheduled?

Courses for relevant staff members are designed based on regular supervisory visits to the field, and evaluation of performance in comparison to job descriptions and expected outputs. The supervisory section facilitates the decision of what type of training the health workers receive based on the prepared profile of each targeted staff member, the RTC prepares relevant training materials and designs a timetable along with a planned outline for the course. After completion of all necessary preparations, targeted staff members receive a two-week prior notice with the date and venue of the training course. Invitation letter are sent to other organization working in the relevant field.

Special courses on a specified subject are sometimes designed in cooperation with our partner organizations like WHO, UNICEF, MSF, HNI, and Oxfam.

Water and Sanitation

Objective:

- To provide safe drinking water, sanitation facilities and hygiene education for the community members.

Water and Sanitation is one of the most prominent health interventions. This is especially true in Afghanistan today. With the country suffering from 4 years of continuous drought, the socioeconomic life of the people has been severely affected resulting in internal migration rates equal to the immigration rates due to the two decades of civil war in the country.

After the successful implementation of a Water & Sanitation pilot project in the Uruzgan Province, a community-based water & sanitation project was designed for the province in late 2000. The aim was to provide public 250 wells and 750 sanitary latrines in order to tackle the prevailing drought in the area, prevent disease prevalence and as a result diminish the rate of internal migrations. Stichting Vluchteling and UNICEF were the chief financial partners for the project as well as Bill Gates Foundation. Up December 31st 2001, 204 wells with hand pump, 96 wells without hand pump and 525 latrines have been installed. The wells and more 225 latrines are planned to be completed by the end of March 2002.

The main obstacle that we have faced with this project is the constant decrease in the water table due to the ongoing drought, causing some of the wells to wither. It seems that with the current available technology we will not be able to cope with the ongoing problem. We are trying to change the strategy and provision for advanced instruments and appropriate technologies.

UNICEF experts (Mr. Abdullah Qadeer, Mr. Aung Cheein and Mr. Aliejo Bejemino) have monitored progress of works few times and have provided technical advises. Jas van Mierlo from NOVIB also visited the project and commended the quality of works done.

Internally Displaced People

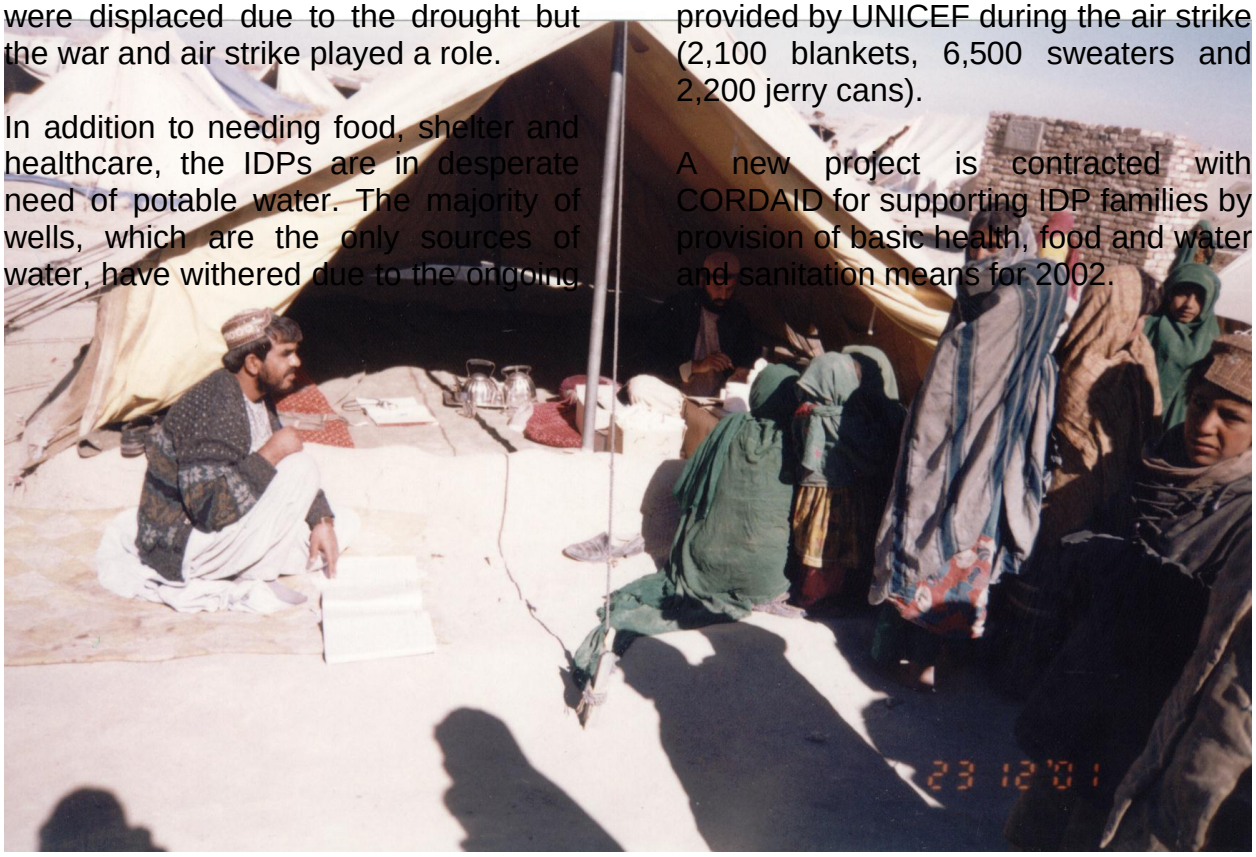
Objective:
Respond quickly at emergence of outbreaks of diseases and internal displacement of people in the target areas.

The major affliction in the region during last year, like the previous couple of years, has been the drought. Almost the entire population of Raig District in Kandahar has been displaced due to the drought and is settled mostly in Panjwaie (along the Arghandab River) and the Maywand districts, either in camps or in their relative's houses. Based on a survey that was launched in December 2000, there were an estimated 1,475 families settled in IDP camps at the end of 2000. But according to our fore mentioned survey in October 2001 these numbers had increased to 3,625 families. The majority of families were displaced due to the drought but the war and air strike played a role.

In addition to needing food, shelter and healthcare, the IDPs are in desperate need of potable water. The majority of wells, which are the only sources of water, have withered due to the ongoing drought and alternative sources haven't yet been introduced.

To address the IDPs' health needs, AHDS has been providing health services consisting of mother and child health care, immunization, health education, early diagnosis and treatment of common diseases and referrals through its mobile unit (1,222 children vaccinated against measles, 5,127 clients received health education and 7,760 patients were treated and received free medicines). In addition, our regional office facilitated the distribution of certain non-food materials provided by UNICEF during the air strike (2,100 blankets, 6,500 sweaters and 2,200 jerry cans).

A new project is contracted with CORDAID for supporting IDP families by provision of basic health, food and water and sanitation means for 2002.



Repatriation

AHDS had a joint project with International Organization for Migration (IOM) to strengthen the health care qualified human resource capacity in Afghanistan through assisting Afghan professionals in Pakistan to return to identified jobs. Emphasis is made on targeting rural areas for return and priority is given to female applicants. The project provided basic relocation assistance and supplementary training according to the set criteria. 16 health professionals (doctors, pharmacists, nurses and laboratory technicians) were provided employment opportunities by AHDS and returned to their home country in the year 2001. In addition to the trainings in our regional training center, 7 of them have received 6-week refresher courses in the teaching hospital of MRCA (Medical Refresher Courses for Afghans).

IOM team, Ms. Kristina Hellgren and
Mr. Shamel Mahmoddi
during field visit in AHDS' health facilities

Dr. Naim Rahimi our Project coordinator in a meeting with community members

Community Participation

Since the Alma Ata conference of 1978 a primary health system with full involvement of the community has been seen as the key to bringing about health for all. Since health is a complex phenomenon, all predisposing factors contributing to the generation of illnesses in the community must be taken into consideration.

The literacy rate in our catchments areas is estimated at 10 to 15 % for males and 0 to 1 % for females. The family size is between 8 to 12 and the monthly income of a medium family is estimated to be US$ 8.50 to $ 20.00.

Many diseases in developing countries are a direct result of poverty. A poor person has little money, little food, and little power. Poverty does not usually disappear when a country becomes prosperous. Most commonly the rich become richer, and the poor stay at the same level or slide even deeper into poverty and dependence.

As health workers we must be aware of the forces, which act against the poor and lock them into a life-style of poverty.

In Afghanistan at present, the basic services provided to the community

including education, health care, sanitation, agriculture and veterinary and environmental preservation are totally reliant on outside assistances.

Organizations working with the communities need to take into consideration appropriate approaches and field-tested techniques. Because it is a natural instinct to want change in one's life and environment in a consistent and perpetual manner, we have made tremendous efforts to use this natural force to mobilize the communities and get them to participate in certain health related interventions.

How communities contribute to our health programs:

Communities contribute in most parts of the program implementation. Site selection for health facilities, provision of land or space for our health facilities, ensuring of security for maintaining the activities and providing political and moral support, are the most crucial supports of the communities. The communities accept cost sharing as for a step towards the sustainability of the program. Community contribution was US$ 57,177 in year 2001: US$ 32,417 in cash as patients' consultation partial fee and US$ 24,760 in kind to water and sanitation project (US$ 15,480 as labor cost and US$ 8,920 as raw construction material).

Jean Francois Cautain, Afghanistan Program Coordinator, European Commission, talking with community members.

Coordination and Cooperation

Coordination and cooperation in health, as well as other sectors, are crucial in our unique situation. Since a great gap, due to lack of infrastructure, in all sectors is tangible in the country, the existing coordinating bodies are the mainstay of delivering sound approaches and leading of effective and efficient services.

AHDS is an active member of Afghan NGOs Coordination Bureau (ANCB), Afghan Coordinating Body for Afghan Relief (ACBAR), Afghanistan Programming Body (APB), National Technical Coordination committee (NTCC), MCH Task Force, Nutrition Task Force, and the Health Education Task Force. Furthermore, at regional level AHDS is a member of Health Coordination Committee, Regional EPI Management Team, Regional Malaria Control Subcommittee and the Water Sanitation Subcommittee.

After the events of September 11, the world entered a new phase of solidarity and cohesion in order to share their perceptions, values, interests and anticipate risks of further humanitarian crisis worldwide. AHDS actively participated in all meetings and gatherings in this regard and sincerely presented the needs and expectations of our innocent children and mothers. AHDS was one of the primary sources of information for the ongoing humanitarian crisis in the Southern region of Afghanistan.

As a result of our participation in these coordination meetings, we were able to attract more partners for our programs. AHDS played an active role in Nutrition Task Force meetings and was considered as the main counterpart for regional emergency nutrition program by UNICEF and other partners.

AHDS' MCH/CHC in Dehrawood, Urozgan

Finance

AHDS' total available funds in the year 2001 were USD 1,116,205. AHDS has adopted a Double Entry System for all of its accounts in the main and regional office. All the financial aspects of the regional office have been audited quarterly through the Finance Department of the main office. Almas Chartered Accounting Company has facilitated the external audits two times during the year 2001. It is worth mentioning that AHDS Primary Health Care Program, funded by Bill & Melinda Gates Foundation, has been audited externally through the mentioned auditors from 1st Jan 01 to 31st Dec 01. A copy of the audit report is attached as an Appendix.

The following table summarizes the donations in hand in the year 2001.

Donors	In Cash	In Kind	Total in US$
Bill and Melinda Gates Foundation	889,291	0	889,291
Unicef	39,800	70,008	109,808
Stiching Vluchteling (SV)	51,979	0	51,979
Community	32,417	24,760	57,177
IOM	7,950	0	7,950
Total	**1,021,43**	**94,768**	**1,116,205**

It is worth mentioning that during the year 2001, the community contributed USD 32, 417 in cash through cost recovery and an additional estimated US$ 24,760 in kind to the water and sanitation project.

Grants used in year 2001:

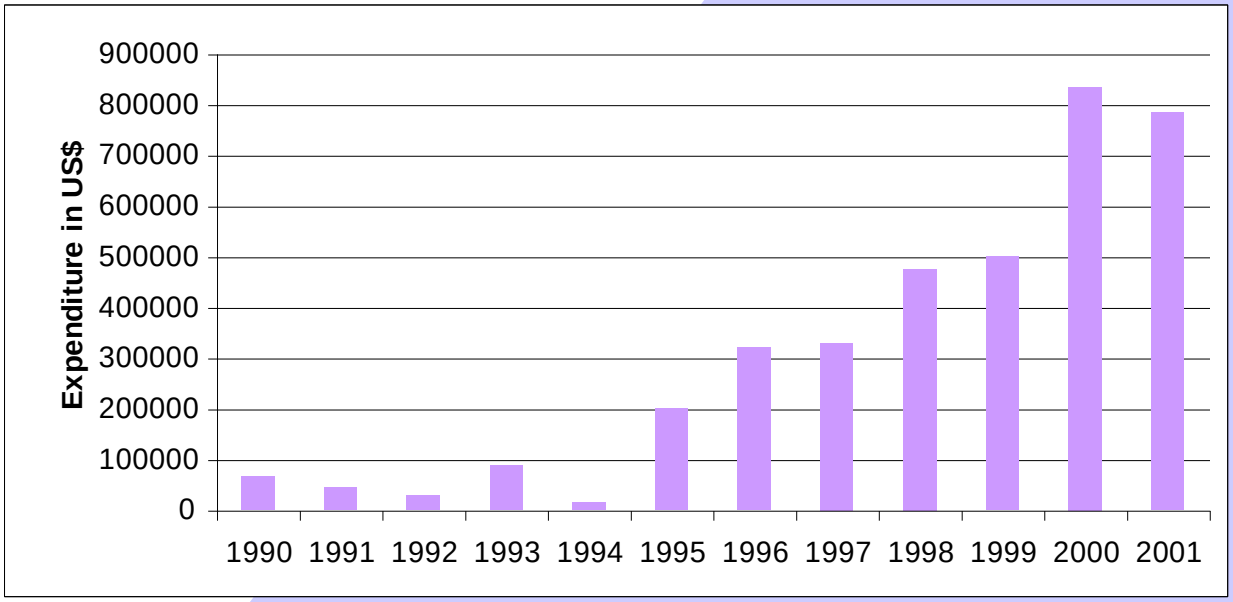
Donors	In Cash	In Kinds	Total in US$	Percentage
Bill and Melinda Gates Foundation	653,885	0	653,885	83.31
Unicef	17,154	47,786	64,940	8.27
Stiching Vluchteling (SV)	37,221	0	37,221	4.74
Community	0	24,760	24,760	3.15
IOM	4,032	0	4,032	0.51
Total	**712,292**	**72,546**	**784,838**	**100**

Note: the remaining balance of the grants will be used for the continuation of the program in (the first months of) year 2002.

Expenses details:

Description	Amount in US$	Percentage
Operational Expenses:		
• Medicine & Medical Material	175,947	22.4%
• Capacity Building	6,854	0.9%
• Health Education	7,428	1.0%
• Maintenance of Public Health Facilities	6,102	0.8%
• Water & Sanitation	120,713	15.4%
• Personnel Salary	347,914	44.3%
• Relief for IDP	26,300	3.3%
• Other Operational Expenses	57,699	7.3%
Subtotal	**748,957**	**95.4%**
Administration Cost	**35,881**	**4.6%**
Grand Total	**784,838**	**100.0%**

Yearly expenditures of AHDS projects:



External Financial Audit

M. ALMAS & CO.
CHARTERED ACCOUNTANTS

MAIN CHAMBERS,
3RD FLOOR, BLOCK - 7,
3 - TEMPLE ROAD,
LAHORE.
TELE: 6306835 - 6362783
FAX: 6306399
E mail: malmas@brain.net.pk

AUDITORS' REPORT TO

AFGHAN HEALTH AND DEVELOPMENT SERVICES (AHDS)

We have examined the annexed statement pf revenue and expenditure together with notes forming part thereof of the Primary Health Care Program in Kandahar/Urozgan, funded by Bill and Melinda Gates Foundation, USA, for the year ended December 31, 2001 with the books and records maintained at Peshawar. Our examination was made in accordance with the generally accepted auditing standards and accordingly included such tests of the accounting and such other records as were considered necessary in the circumstances and we report as follows:

a) Expenditure incurred inside Afghanistan is not susceptible to independent audit verification. It has been verified by us only to approval thereof by the AHDS management;

b) Distribution of medicines and other materials has not been subject to our verification;

c) Included in equipment and supplies is cost of hand pumps amounting to Rs. 704,939 purchased for Water Sanitation project, another project of AHDS.

Except for the foregoing and the affect thereof on the enclosed statement, in our opinion the enclosed statement of revenue and expenditure is in accordance with the books and records maintained at Peshawar and the accounting policies stated in note number 2 therein and give a true and fair view of the revenue and expenditure for the year ended December 31, 2001.

CHARTERED ACCOUNTANTS

Lahore
March 2, 2002

ALMAS & CO.
ARTERED ACCOUNTANTS

AFGHAN HEALTH AND DEVELOPMENT SERVICES (AHDS)
PRIMARY HEALTH CARE PROGRAMME IN KANDAHAR/UROZGAN
FUNDED BY BILL & MELINDA GATES FOUNDATION

STATEMENT OF REVENUE AND EXPENDITURE
FOR THE YEAR ENDED DECEMBER 31, 2001

	NOTES	2001 RUPEES	2001 US $	2000 RUPEES
REVENUE:				
Grants		45,063,700	781,000	85,610,570
Less: second instalment received in advance net of 3% service charges		-	-	43,711,789
		45,063,700	781,000	41,898,781
Interest		1,296,731	21,286	1,311,351
Exchange gain		2,755,446	-	2,733,789
Total revenue		49,115,877	802,286	45,943,921
EXPENDITURE:				
Services	3	1,856,026	31,442	1,769,411
Equipments and supplies	4	12,296,788	198,462	17,103,263
Maintenance	5	375,614	6,102	752,653
Operations	6	25,561,832	417,879	21,278,700
Total Expenditure		40,090,260	653,885	40,904,027
EXCESS OF REVENUE OVER EXPENDITURE		9,025,617	148,401	5,039,894
FUND BALANCE BROUGHT FORWARD		5,039,894	87,005	-
		14,065,511	235,406	5,039,894
EPRESENTED BY:				
Balance at banks				
- At USA		13,249,855	221,755	48,026,902
- At Peshawar		412,673	6,907	645,088
Cash in hand		402,983	6,744	79,693
		14,065,511	235,406	48,751,683
Less: grant received in advance for 2001		-	-	43,711,789
		14,065,511	235,406	5,039,894

The annexed notes form an integral part of this statement.

DIRECTOR

Further actions needed

- Considering all the facts and problems that our country is currently facing, it is fully understandable that our people need stability, peace, infrastructure and sustainable developmental programs.
- Need assessments surveys should be done in order to focus on the real needs of the communities.
- Baseline surveys are crucial for the health programs' efficiency.
- A strategic plan considering the multi dimensions of health care based on equity, acceptability and accessibility for all Afghans is needed.
- The technical aspects of the program must be boosted in order to obtain more critical and analytical health data.
- To be focused on women and neonatal mortality. There is great need for up grading gender roles in the family, community and society through improving of livelihoods. For this reason projects like vocational training for women, income generation and micro credits through our MCH clinics will play a great role to gradually empower women.

Constraints:

- Lack of infrastructure in all sectors.
- Projects are mostly depended on outside funding.
- 4 years of continuous drought.
- Due to existent circumstances, emergency intervention is the practice of most donor organizations.
- War and insecurity.
- Lack of local professional staff.

CONCLUSION

Afghanistan continues to face an incredible number of obstacles on its road to recovery from more than two decades of war and four years of continuous drought. The civil society has become increasingly dependent on services provided by national and international NGOs. In the year 2001, AHDS continued to play a crucial role, not only by providing primary health care services, but also by engaging the communities to take responsibility for their own problems and find ways and means to correct their shortcomings.

Quantitative evaluations show that in year 2001 AHDS activities improved the overall health status of the target community by:

- Continuing the usual and existing types of interventions
- Increasing the number of beneficiaries
- Providing the only source of health care to the target community by keeping the health facilities open and functioning during the US air strikes
- Conducting recurrent seminars and workshops and on the job training for both male and female staff.
- Increasing our catchments area coverage to the underserved areas.
- Increasing the EPI routine

As a result, there was an increase in healthy practices in the community, an increase in the number of deliveries assisted by trained TBAs, and a positive change was observed in the disease pattern resulting in a relatively decreased morbidity and mortality rate for the catchments area.

Human Resources

Permanent Members of AHDS' Board of Directors:

Name	Profession	Sex	Function
Aziz R. Qarghah	Post Graduate Study in Education Bachelor of Arts	M	Director of AHDS
Suraya Sadeed	Bachelor of Arts: MA in Child Psychology	F	Director of Help the Afghan Children (HTAC)
Sadozai Pana	Engineer	F	Director of Women Development Program for Afghanistan (WDPA)
Sayed Jawaid	Engineer	M	Director of Helping the Afghan Farmers Organization (HAFO)
Mohammad Masoom Stanekzai	Executive Mastering in Business Administration	M	Managing Director, Agency for Rehabilitation and Energy Conservation in Afghanistan (AREA)
Abdul Samad Stanekzai	Bachelor of Agriculture	M	Executive Chairman for Afghan Development Association (ADA)

Honorary Members of Board of Directors:

Name	Profession	Sex	Function
Shah Waliullah Siddiqi	Doctor (MD)	M	Medical Officer WHO Iraq
Sayed Mohammad Amin Fatemi	Doctor (MD)	M	Medical Advisor WHO EMRO
Ahmad Shah Jalal	Educator (PhD) Chemistry	M	Retired
Najibullah Mojadedi	Doctor (MD)	M	Medical Advisor WHO EMRO
Ghulam Rabani Popal	Doctor (MD)	M	WR WHO Iraq
Ghulam Jilani Popal	Bachelor of Law	M	Retired managing director of ADA

Staffing:

Locations	Administrative staff		Technical staff		Support staff		Total
	Male	Female	**Male**	Female	**Male**	Female	
Main Office	10	1	2	1	7	0	21
Regional Office	6	0	9	2	11	0	36
Provincial Office	2	0	0	0	5	0	7
Water/Sanitation	0	0	5	0	1	0	6
Regional Training Center	1	0	3	1	3	1	9
Health Facilities	7	4	116	43	42	14	226
Total							**305**

Health Information System

Health information is one of the basic tools for management and future planning as well as the impact of certain interventions while comparing the consequences. AHDS' Health Information System (HIS) is established in 1997 and consisting of various formats such as community diagnosis, patients' statistics, immunization, reproductive health, morbidity and mortality, laboratory, health education, TBA activities and water and sanitation with relevant registration books and tallies for each. Health facilities send the information on monthly basis to the HIS section of regional office, where reports are processing and further actions are taken upon.

	Arghandab	Arghistan	Kandahar City	Daman	Dand	Deh Rawood	Maywand	Panjwaie	Tirinkote MCH	Wayand	Total
Obstetric Cases											
Prenatal Care	732	662	1012	481	463	362	1088	676	396	565	**6437**
Postnatal Care	261	280	200	134	152	74	149	146	184	248	**1828**
Normal Delivery	45	29	100	0	28	52	90	21	47	51	**463**
Abnormal Delivery	4	3	11	0	2	1	9	17	3	9	**59**
Abortion	104	58	38	14	45	48	90	50	31	44	**522**
Common Problems of Pregnancy	366	315	395	193	197	138	423	198	201	373	**2799**
Toxemia of Pregnancy	22	2	5	1	0	9	2	2	5	8	**56**
Sub-Total	1534	1349	1761	823	887	684	1851	1110	867	1298	**12164**
Referral	21	19	10	0	0	9	14	8	11	6	**98**
Gynecological Cases											
Pelvic Inflammatory Diseases	354	111	188	122	711	819	382	314	467	420	**3888**
Vaginitis	315	296	381	290	208	153	282	258	150	327	**2660**
Prolaps	56	128	50	7	26	50	50	58	43	56	**524**
Menstrual Disorders	251	102	355	52	315	117	467	460	712	348	**3179**
Dysfunctional Uterine Bleeding	133	85	107	47	189	70	90	17	66	65	**869**
Infertility	86	73	61	20	73	83	122	88	52	105	**763**
Sub-Total	1195	795	1142	538	1522	1292	1393	1195	1490	1321	**11883**
Referral	25	3	8	0	5	8	3	7	4	0	**63**
Family Planning											
Health Eduction	1785	1831	3242	2469	3134	1213	1294	1214	3340	1610	**21132**
Condom	30	7	51	2	29	106	5	67	60	20	**377**
Oral Contraceptives	286	204	149	112	266	92	128	159	296	136	**1828**
Depot Progesteron	34	60	35	53	111	66	34	67	196	77	**733**
Safe Period	18	0	16	0	200	30	10	36	50	331	**691**
Nutrition											
Growth Monitoring	1290	348	1316	2391	1131	209	308	55	1010	885	**8943**
Food Demonstration	2058	1396	965	1124	576	511	1045	2062	1113	2398	**13248**
Health Education	2529	2876	3473	3023	4251	773	1590	1929	2960	3467	**26871**
TBA Training											
New TBAs	0	0	0	0	30	0	0	0	0	0	**30**
Supervised TBAs	402	364	0	398	434	659	152	262	603	353	**3627**
Re-supplied TBAs	402	364	0	398	434	659	150	262	603	353	**3625**
Delivery By TBAs	701	388	0	270	305	622	207	449	720	475	**4137**
Home Visits By TBAs	842	421	0	434	332	1148	182	465	1453	1093	**6370**
Referred By TBAs	33	5	0	16	9	141	3	5	33	15	**260**

Category	Diseases		Under 1-Y		1-4 Y		5-14 Y		15 Y & Over		Children		Total		Grand Total
			M	F	M	F	M	F	M	F	<5	<15	M	F	
ARI	Common Cold		1523	1202	2164	1779	2325	2229	4862	4587	6668	11222	10874	9797	20671
	Pharyngitis		376	317	1623	1266	3107	2634	4788	4829	3582	9323	9894	9046	18940
	Otitis Media		1910	1437	2376	1845	1434	1065	1307	1364	7568	10067	7027	5711	12738
	Laryngitis		34	40	145	143	216	349	435	734	362	927	830	1266	2096
	Bronchitis		1150	856	2443	1806	2285	2015	6689	6433	6255	10555	12567	11110	23677
	Pneumonia		1672	1232	2544	1790	1166	865	1393	1260	7238	9269	6775	5147	11922
Total Acute Respiratory Tract Infections			6665	5084	11295	8629	10533	9157	19474	19207	31673	51363	47967	42077	90044
Chronic Obstructive Pulmonary Diseases			1	2	11	7	8	16	548	284	43	27	568	309	877
Bronchial Asthma			59	36	105	55	207	178	1092	1351	80	99	1463	1620	3083
Diarheal Diseases	Simple Diarrhea		2552	2282	4228	2917	1810	1385	2942	2152	11979	15174	11532	8736	20268
	Bacterial Dysentry		1634	1483	3713	2706	1553	1156	2801	1829	9536	12245	9701	7174	16875
	Amoebiasis		234	249	1024	840	1056	785	3046	1693	2347	4188	5360	3567	8927
	Giardiasis		36	50	284	202	374	271	1099	614	572	1217	1793	1137	2930
	Cholera (suspected)		60	44	44	29	60	39	93	47	177	276	257	159	416
	Total Diarrheal Diseases		4516	4108	9293	6694	4853	3636	9981	6335	24611	33100	28643	20773	49416
	No Dehydration		1762	1670	3490	2706	2139	1585	3890	2742	9628	13352	11281	8703	19984
	Some Deydration		1178	1070	2108	1481	850	646	1707	1037	5837	7333	5843	4234	10077
	Sever Dehydration		141	130	236	211	171	148	280	215	718	1037	828	704	1532
Worms			57	65	1405	1246	2273	1635	1933	1119	2773	6681	5668	4065	9733
EPI Targeted	Measles		14	20	75	67	60	45	13	10	176	281	162	142	304
	Tetanus		1	0	0	0	0	1	0	0	1	2	1	1	2
	Poliomyelitis		0	0	2	1	0	0	0	0	3	3	2	1	3
	Diphtheria		0	0	0	0	0	2	0	3	0	2	0	5	5
	Whooping Cought		39	37	172	117	170	119	23	13	365	654	404	286	690
	Tuberculosis (Pulmonary)		0	0	1	2	8	15	42	155	3	26	51	172	223
Extrapulmonary TB			0	0	2	0	3	4	18	30	2	9	23	34	57
Eye	Conjunctivitis		642	560	1528	1247	1564	1186	2096	2546	3977	6727	5830	5539	11369
	Trachoma		0	0	5	10	6	5	23	30	15	26	34	45	79
	Others		8	13	37	38	70	49	306	145	96	215	421	245	666
	Total Eye Diseases		650	573	1570	1295	1640	1240	2425	2721	4088	6968	6285	5829	12114
Skin Disorders	Pyodermia		209	193	744	654	1261	914	1544	1151	1800	3975	3758	2912	6670
	Scabies		2	7	75	76	140	127	426	370	24	427	643	580	1223
	Leishmaniasis		0	6	43	53	54	42	19	15	102	198	116	116	232
	Fungal Infection		99	93	250	214	256	141	297	318	656	1053	902	766	1668
	Eczema		163	96	312	319	570	524	1242	1183	890	1984	2287	2122	4409
	Total Skin Diseases		473	395	1424	1316	2281	1748	3528	3037	3472	7637	7706	6496	14202
Infectious Diseases	Malaria	Clinical	43	45	356	363	786	601	2032	1208	807	2194	3217	2217	5434
	Malaria Microscope	Plasmosium Vivax	6	3	86	53	154	94	296	171	148	396	542	321	863
		P. Falciparum	1	1	13	11	45	19	36	30	26	90	95	61	156
		Mix	0	0	3	6	7	8	10	4	9	24	20	18	38
	Total Malaria		50	49	458	433	992	722	2374	1413	990	2704	3874	2617	6491
	Typhoid Fever		12	13	293	193	741	526	1061	720	511	1778	2107	1452	3559
	Hepatitis		2	6	37	17	34	25	109	63	62	121	182	111	293
	Meningitis		1	1	6	2	14	7	6	2	10	31	27	12	39
	Rabies		0	0	0	0	0	0	0	0	0	0	0	0	0
	Total Infectious Diseases		65	69	794	645	1781	1280	3550	2198	1573	4634	6190	4192	10382
CVD	Hypertension		0	0	1	0	1	13	1386	4457	1	15	1388	4470	5858
	Chronic Heart Failure		0	0	0	0	1	2	56	22	0	3	57	24	81
	Other Heart Diseases		0	3	9	3	19	17	118	137	15	51	146	160	306
	Total Cardiovascular Diseases		0	3	10	3	21	32	1560	4616	16	69	1591	4654	6245
Leprosy			0	0	0	0	1	1	0	0	0	2	1	1	2
Goiter			0	0	0	0	0	0	0	11	0	0	0	11	11
Diabetes			0	0	0	0	0	0	25	15	0	0	25	15	40
Dependency			0	0	0	0	0	0	6	0	0	0	6	0	6
Musculoskeletal Disorders			2	1	13	25	348	602	6625	15468	41	991	6988	16096	23084
Peptic Diseases			0	2	6	8	453	813	9610	16994	16	1282	10069	17817	27886
Urinary Tract Infections			47	21	325	230	591	616	4508	7269	623	1830	5471	8136	13607
Anemia			27	31	373	285	621	738	2026	12256	716	2075	3047	13310	16357
Malnutrition		Moderate	668	701	1102	1009	96	70	36	159	3480	3646	1902	1939	3841
		Severe	451	537	602	668	39	19	4	7	2258	2316	1096	1231	2327
		Total Malnutrition	1119	1238	1704	1677	135	89	40	166	5738	5962	2998	3170	6168
Neuro-Psychiatric Disorder			0	1	8	3	34	51	936	619	12	97	978	674	1652
Oro-Dental Disorders		Tooth Extraction	0	0	1	3	27	30	1575	1104	1104	61	1603	1137	2740
		Others	2	3	23	19	117	86	946	845	47	250	1088	953	2041
		Total ODD	2	3	24	22	144	116	2521	1949	1151	311	2691	2090	4781
Gynecological and Obsetric cases			0	0	0	0	0	62	0	23886	0	62	0	23948	23948
Surgical Cases		War Accident	3	6	3	4	9	4	26	26	16	29	41	40	81
		Routine Wounds	47	54	463	359	1122	601	3283	824	923	2646	4915	1838	6753
		Mine Accident	3	5	1	0	15	2	39	91	9	26	58	98	156
		Acute Surgical Cases	9	8	46	30	87	51	296	186	93	231	438	275	713
		Total Surgical	62	73	513	393	1233	658	3644	1127	1041	2932	5452	2251	7703
Other Diseases			408	404	841	754	1400	1274	5448	6964	2407	5081	8097	9396	17493
Symptoms			124	129	296	271	518	517	2870	4843	820	1855	3808	5760	9568
		Grand Total:	14331	12295	30262	23745	29316	24645	82446	132646	81444	134035	156355	193331	**349,686**
Referral			170	139	345	305	417	337	667	843	959	1713	1599	1624	3223
In-patient			49	17	99	59	113	66	316	590	224	403	577	732	1309

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