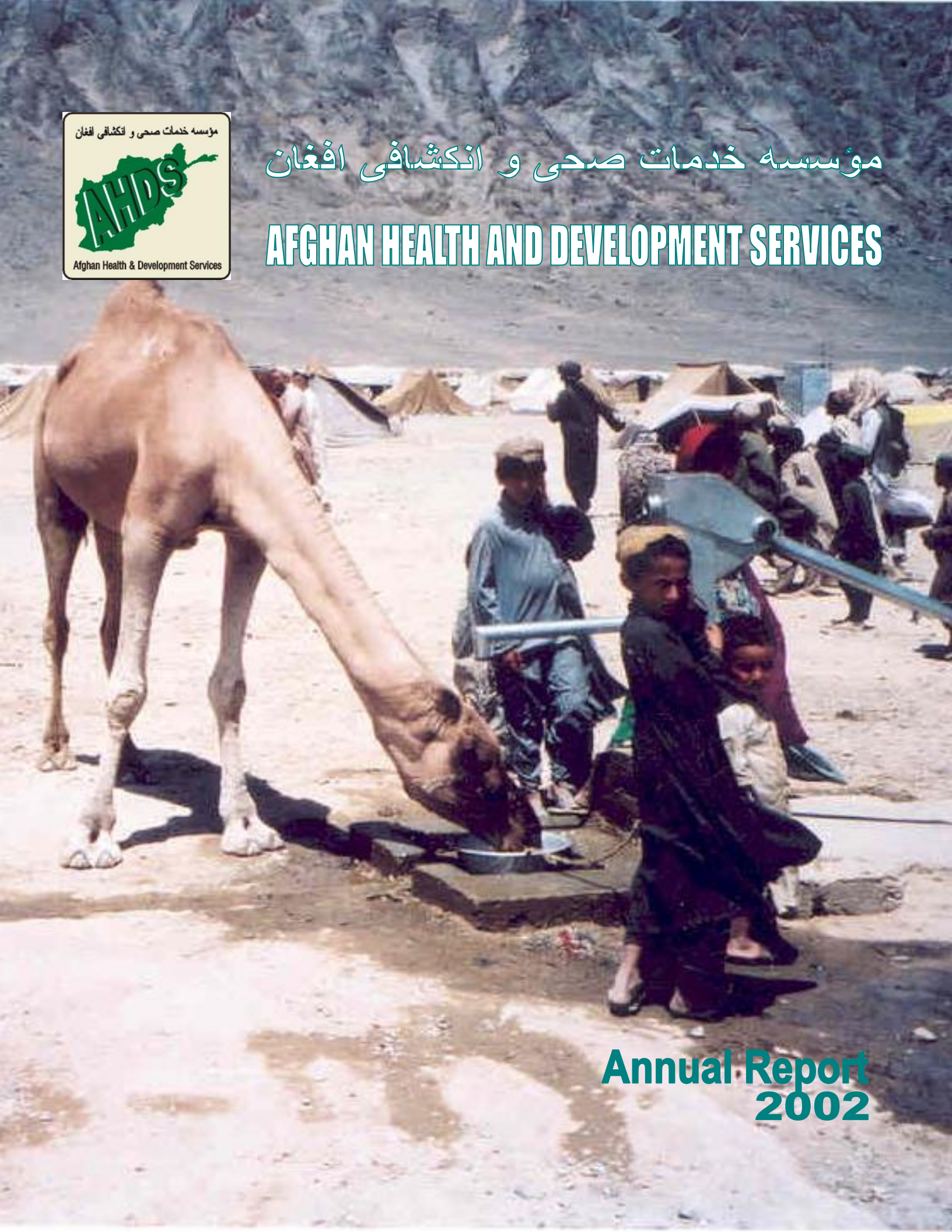



# مؤسسه خدمات صحی و انکشافی افغان

# AFGHAN HEALTH AND DEVELOPMENT SERVICES

## Annual Report 2002

# VISION

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

To achieve improved health status and living condition of the Afghan communities through provision/integration of basic health services based on rehabilitation/reconstruction of community infrastructure and relevant initiatives for capacity building and development.

# MISSION

# POLICIES

1. **Rehabilitation and development of infrastructures**
2. **Equitable service regardless of gender, ethnic, religious, and political affiliations**
3. **Focus on the vulnerable: women and children, and remote communities**
4. **Community based set-up for sustainable development**
5. **Affordability and cost effectiveness**
6. **Decentralized system with full participatory approach**
7. **Integrated approach to provide comprehensive health and social services**

# CONTENTS

Afghan Health & Development Services (AHDS)

# Forward

*After 23 years of conflict, the challenges facing Afghanistan are enormous. The road to recovery and reconstruction calls for men and women with the knowledge, expertise and resources to overcome these problems and pave the road to a peaceful and prosperous future.*

*Afghan Health and Development Services (AHDS) has been striving to provide realistic solutions to the health problems of Afghanistan by continually working with Afghanistan's Ministry of Health (MoH) and other health providers since 1990. AHDS had the privilege of participating on the initial five-year health master plan of Afghanistan's Interim-Government (AIG) in exile (1989-1992) which has been used as the framework of the revised master plane. In July 2002, Georgetown University (Washington DC) hosted the Afghanistan-America Summit on Recovery and Reconstruction, in which I had the honor of participating, with the aim of brining experts from many fields to set priorities and develop realistic strategies to rebuild Afghanistan. The Summit included the participation of Ministers of Afghanistan's Transitional Government, US government officials and leaders of NGO's and the academic community. During the summit the Health Working Group, led by Afghanistan's Minister of Health, prioritized Reproductive Health/Maternal Health, Mental Health, Child Health and Communicable Diseases as the top four important health issues to be addressed in short and long-term for Afghanistan's reconstruction. The objectives, strategies and implementation plans were inline with the revised Master Plan for Reconstruction and Rehabilitation of the Health System in Afghanistan (2002-2006).*

*I am proud to say that AHDS, as the leading health provider in Southwest Afghanistan, has addressed Reproductive Health/Maternal Health, Child Health and Communicable Diseases, as priority areas in health, in a comprehensive manner through its Primary Health Care Program for the past 8 years. The accomplishments of the program are depicted in this annual report. It is my strong desire to incorporate Mental Health services as an integrated part of the Primary Health Care Program in the near future.*

*Unfavorable circumstances and enormous restrictions (mainly financial resources and shortage of professional staff) have put MoH in a very difficult situation in addressing the ever-increasing demand for public health services. Therefore, a helping hand from the NGO community, working in the health sector, will continue to be crucial in the provision of "health for all" in the foreseeable future.*

*Our generous donors and committed staff have made our success possible. With their support and dedication, we have been able to provide life saving health services to 670,000 individuals in year 2002. We look forward to continued cooperation in making "health for all" a reality to every member of our targeted communities in the coming years.*

*Aziz R. Qarghah*
*Director*

**Year 2002 was a challenging year for AHDS as one of the few developmental oriented organizations in Afghanistan.**

# Executive Summary

The establishment of an interim government followed by a transitional government in Afghanistan has changed the country's overall context, priorities, intervention strategies, assumptions and challenges.

During the last year, the international community tried to start the process of post-conflict reconstruction by focusing its efforts on providing support and rehabilitation activities to Afghanistan. Massive return of refugees from Pakistan and Iran, voluntary work of Afghans with dual nationality (from western countries) and willingness of other countries for huge amount of monetary and technical support created optimism. A number of new national and international NGOs began operations inside the country. All these factors have led to a general atmosphere of optimism and hope amongst the people. The Afghan people are thankful to the international community for their involvement in the provision of peace and social services. Important steps such as drafting a National Development Framework, a Health Master Plan and a Minimum Package of Health Services have been initiated by the transitional government with the aid of some national and international organizations. However, after one year of post-conflict reconstruction, there are very minimal practical changes observed on the ground-- the country continuous to be griped by insecurity, lack of basic necessities, violation of human rights and poverty. The poor management and coordination in the flow of aid and international organizations, mushroom like eruption of new national NGOs, flow of ideas from experiences in different contexts, rush of donors to exhaust earmarked funds, emphasis on quick impact projects (not practical for developmental work), the eagerness of Afghans for reconstruction, and continued drought overshadowed the need for long term national development strategy. Due to poor long-term strategic planning and a "lets do something" approach, most of the interventions have not yielded the anticipated results. In hindsight, the flow of aid to Afghanistan, over the last year, had the following major shortcomings:

- Lack of sufficient baseline surveys
- Shallow coordination
- Not taking into consideration the serious shortage of manpower in project/program design
- Too much reliance on international NGOs and expatriates with limited or no prior work experience in Afghanistan
- Rush in implementing "***ideas"*** rather than well planned projects and program

**2002 Pledges:**

- To improve the health status of people living in the target areas
- To contribute in reduction of infant, child and maternal mortality
- To improve capacity of Afghan human resources
- To contribute in orientation and planning for rehabilitation and development at the national level

Even though we were faced with many challenges in the past year that resulted in the loss of some staff and as a relative decrease in quantity of service, the quality of our service continued to be outstanding. The negative consequences of these practices can be observed through out AHDS' Primary Health Care projects in the provinces of Kandahar and Urozgan. The flow of aid organizations foreign currencies and foreigners in ***urban*** areas has increased the value of the Afghani as well as market prices. In addition, due to higher paying jobs and better living conditions, many professionals working in rural areas are attracted to urban cities. Consequently, we had high turnover of staff and fewer female staff providing health care this year in comparison to previous years. It is anticipated that there will always be staff turnover, but the above factors have created an atmosphere of negative competition for the few qualified professionals amongst the different entities (i.e. NGOs, UN agencies, and governmental organizations) working in the country; resulting in unusually high turnover rates for national NGOs (in many cases staff have left organizations without the required notification and without completing their contracts).

In order to overcome these challenges in the short run, we should provide more facilities for the staff to be able to compete with the international and UN agencies and study the possibility of ***training Auxiliary Midwives*** in our target districts, so they will be chosen by communities and will be more likely to work only for their own communities, which will mean that extra funding must be obtained to meet these challenges. However, one thing should be kept in mind that these solutions will increase the health cost per capita. Therefore, a better solution for the long run is to establish ***practical coordination*** among training institutions, Ministry of Health, UN agencies and Afghan and International NGOs.

As an Afghan NGO, AHDS felt responsible to build, not only, its own internal capacity but at the same time participate in enhancing the capacity of the ***Ministry of Health***. As a result, we have used every opportunity to advocate for careful, precise, workable and affordable rehabilitative and developmental plans.

IDPs in Marghar Camp, celebrating the Eid

# Projects

**Community Based Integrated Primary Health Care**: Currently AHDS operates 39 health facilities in two rural provinces (Kandahar and Urozgan). European Commission, Bill and Melinda Gates Foundation and Stichting Vluchteling fund this project. In 2002, the direct beneficiaries of AHDS' primary health care program were 670,000 people.

**Water and Sanitation**: the project of 450 wells and 1500 model sanitary latrines, funded by Unicef and Stichting Vluchteling, in Urozgan Province was completed.

**Internally Displaced People (IDP) Assistance**: 4,100 IDP families benefited from basic health services, food and non-food items, water and sanitation means in Kandahar Province. The project was funded by Cordaid for eight months.

**Blanket Supplementary Feeding Program**:

- Unicef supported AHDS' two nutrition projects for 3,677 IDP children under the age of five, and pregnant and lactating mothers in Panjwaie.
- Unicef supported AHDS' nutrition project for 5,498 IDP children under the age of five, and pregnant and lactating mothers in Zeray Dasht.

**Primary Health Care**: in partnership with Mercy Corps, we started rehabilitation of clinics and training of community health workers for Nesh and Chora districts.

**Targeted Supplementary Feeding Program**: Unicef supported AHDS' nutrition project for 17,952 children under the age of five, and pregnant and lactating mothers through 9 MCH centers in Kandahar and Urozgan.

# Target Areas

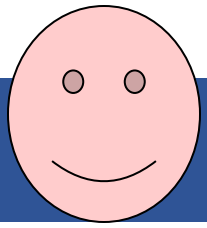
AHDS provided services in the following target areas:

- Arghandab, Arghistan, City of Kandahar, Daman, Dand, Khakrez, Maywand, Panjwaie and Shahwalikote in the Kandahar Province and
- Dehrawood and Tirinkote in the Urozgan Province.

The combined population of the target areas was 1,175,749. ***Direct beneficiaries were about 670,000*** people including the following:

| | |
|---|---|
| Children less than one year old: | 22,177 |
| Children less than five-years old | 111,957 |
| Childbearing age women: | 125,156 |
| Pregnant women: | 33,500 |

# Out Puts



- 359,678 cases (329,142 patients) were treated in the health facilities
- 79.5% of total patients were women and children (261,558)
- 5,876 received antenatal care (3,016 first visit, 1,510 second visit and 1,350 third)
- A total of 6,337 deliveries were assisted
- 21,773 women participated in family planning awareness sessions
- 3,874 couples practiced family planning
- 531 sessions of food demonstration for mothers were conducted
- 24,502 children and women were screened for malnutrition; 2,118 cases of moderate malnutrition were successfully treated
- IDPs in the Panjwaie camps received blanket supplementary feeding for three months (3,099 children and 578 women)
- 152,227 vaccine shots were administered from EPI fixed centers and out reach program, excluding the NIDs and mopping up campaigns
- 13% of children less than one year old in the target communities were fully immunized against the six killing diseases
- 20,076 childbearing age women received tetanus vaccine and 15,439 of them received a second dose (TT2 coverage 12.3%)
- All less children less than five years of age received Polio vaccine through NIDs and Sub-NIDs
- Through 25,831 health education sessions 416,988 individuals received prime health messages
- 20,000 leaflets and 1,000 calendars carrying prime health messages were disseminated
- 1,061 trained Traditional Birth Attendants (TBAs) were regularly supervised. 91 TBA were newly trained in year 2002
- 9 refresher and 8 initial courses and 29 workshop/seminars were conducted in the Training Center (325 females and 337 males benefited from these seminars and workshops)
- 45 staff received different trainings out of AHDS
- 6 managerial staff used training opportunity out of AHDS
- 4,100 families of IDPs were provided with basic health care (facilities, 31,905 patient received treatment and health education, 4,810 children and 2,353 women vaccinated), food items (469 metric tons) and non-food items (4,500 pressure cookers, 3,000 jerricans and 67,040 soaps) and water and sanitation (19 water wells and 261 bathrooms and latrines)
- The project of 300 Shallow wells improved with hand pump and 750 sanitary latrines were completed in Urozgan (continued from previous year).
- 38 Health facilities and one mobile health team were functional
- 95 job opportunities existed for females, out of which 54 were occupied at the end of year
- Rehabilitation of two Comprehensive Health Centers is in progress
- Training of 21 Community Health Worker is on going
- Blanket Supplementary Feeding is started for two IDP camps since December 2002
- Community contribution through consultation fee was US$ 46,567 and in kind for PHC program including water and sanitation was equal to US$ 11,260

# Basic Health Services

The Community Based Integrated Primary Health Care program has been established since 1995 in Kandahar and Urozgan provinces. The overall objective is *to reduce morbidity and mortality rates with special focus on mother and child health by increased accessibility to promotive, preventive and curative care through efficient, cost effective and affordable primary health care*. The program was running with a grant from the Bill and Melinda Gates Foundation in the first months of 2002. From May 1st 2002, the European Commission and Stichting Vluchteling kindly provided funding for continuation of the project. Unicef provided funding for the nutrition and supplementary feeding programs for women and children. The EPI program of MoH/Unicef and the Malaria Control program of HNI were integrated to the package of health services. Expansion of the program to two new districts (Nesh and Chora) has been started in partnership with Mercy Corps.

The main activities of the project for the year were:

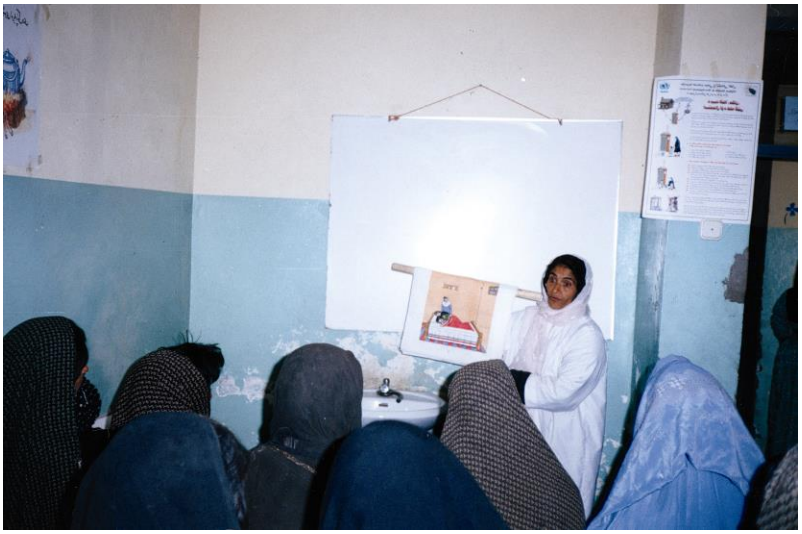
- Provision of maternal and child health care,
- Encouragement and formalization of family planning (to raise community awareness about birth spacing and having fewer children),
- Integrated immunization,
- Nutrition,
- Dealing with epidemics at the district and village level,
- Improvement of hygiene and sanitation practices,
- Increasing community awareness about health and health related problems,
- Development of local human resources and pursuing community participation.

## Facilities:

- **The provision of health services was rendered by the following facilities8 Comprehensive Health Centers including Mother and child Health care at district level**
- **2 Mother and child Health centers in Kandahar and Tirinkote towns**
- **4 Basic Health Centers in the main villages**
- **23 Basic Health Posts at villages by Community Health Workers (CHW)**
- **1,061 Trained Traditional Birth Attendants (TBA)**
- **Training Centers (separate for male and female) in Kandahar City**
- **A mobile team for Internally Displaced People (IDP) and epidemic outbreaks**
- **Central Stocks for medical and nutritional commodities**

# Health Education

AHDS considers health education as a key component for bringing positive changes and promoting healthy lifestyles in communities. During health education sessions the interest and cultural trends of the communities are kept in mind. An open and attractive atmosphere is fostered to allow the active participation of the audience in order to avoid one- way communication that might lend to boredom and lack of interest. Our field workers help people to understand what are the health problems, what are the priorities, what are the causes for these problems and how they can overcome these problems. We try to cultivate these ideas through different media like group discussions, individual discussions and printed material. Clinic staff, community health workers and traditional birth attendants use any opportunity to raise certain health issues among the people and authorities. Despite of certain constraints and hurdles at both sides of the sender of messages and the audiences, fortunately most of the families and individuals (the audience) have been interested to communicate their concerns and health problems through health education sessions and received relevant advises and feedbacks. The communities have been mobilized to absorb the inputs provided by different agencies for their health although at the time being they are still passive receivers.



Based on AHDS guideline for health educators in two national languages (Dari and Pashtu), three training courses were conducted for its male and female health educators this year. Calendars (1,000 copies), leaflets (20,000 copies) and posters containing prime health messages were disseminated to the literate people. Through 25,831 health education sessions 416,988 individuals received prime health messages. Food demonstration was another effective method for nutrition education. The mothers and health educators had 531 sessions of preparing nutritious food. The aim of all these efforts is to enable the communities, families and individuals to: recognize the risk factors of diseases, learn healthy practices, proactively seek preventive measures like immunization, antenatal care, safe water and hygienic foods, carefully dispose wastes especially human wastes properly use sanitary latrines, care for their children in a sound and hygienic way and finally adopt a healthy and positive lifestyle. In fact, achieving these objectives is not something simple, but effective and tangible efforts could encourage us to move in bringing change in the perceptions, practices and behaviors of the communities.

# Communicable and Common Diseases

Poverty and insecurity intensify health problems and oppose trends for alleviation. The current socio-economic and seasonal and geographical conditions in Afghanistan can determine predisposing factors for high incidences of life-threatening diseases such as communicable diseases, malnutrition, obstetric emergencies, and injuries due to mines. This is a well-know fact that more effort should be focused on promotive health and prevention. Since access to health facilities is very low for people, especially in rural areas, provision of medical care is the main occupation for available health professionals. A total of 359,678 cases (329,142 patients) were treated in the health facilities. 79.5% of total patients were women and children (261,558). Prevalent communicable diseases in the catchments areas were acute respiratory tract infection (ARI), different diarrheas, malaria and typhoid fever. Other common problems were peptic disorders, anemia, infectious conjunctivitis, chronic obstructive lung diseases (COPD), intestinal worms, skin infections and reproductive tract infections.

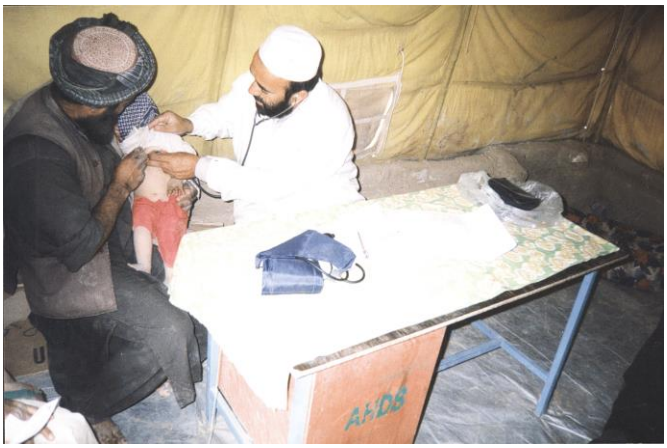
| Children, <5 | Percent | Women | Percent | Men | Percent |
|---|---|---|---|---|---|
| ARI | 46% | ARI | 33% | ARI | 21% |
| Diarrheal Diseases | 34% | Peptic Diseases | 27% | Diarrheal Diseases | 13% |
| Malnutrition | 5% | Anemia | 18% | Peptic Diseases | 12% |
| Infectious Conjunctivitis | 5% | Reproductive tract infection | 13% | Injuries | 12% |
| Skin Diseases | 4% | Diarrheal Diseases | 13% | COPD | 9% |

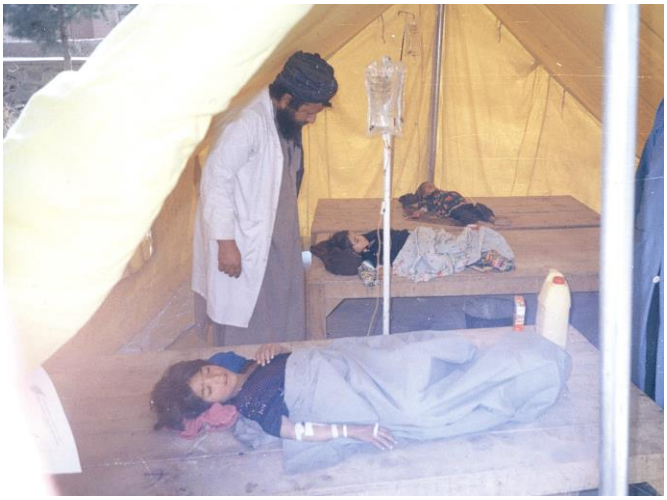
Table shows top five prevalent diseases in year 2002

For better control of communicable diseases, AHDS has built relations with other health agencies like malaria control with HNI, Polio with Unicef and WHO and early warning system with MSF. Kandahar and Urozgan provinces are endemic area for malaria (5,226 cases reported from AHDS facilities in 2002) and polio (in spite of successful NIDs 4 cases are reported). High cases) and worm infestation (10,974 cases) needs special focus on hygiene and sanitation of the target communities. We hope to control these two diseases by improving our health education system and attracting contribution of other sectors like the municipality, Ministry of Education and others.

# Emergency Response

For on time management of health emergencies, an Early Warning System is established with support of Médecins Sans Frontières (MSF), MoH, Unicef and WHO. Any case of communicable diseases or outbreaks in a village is reported immediately. The community health committees, community health workers (CHW) and TBAs are responsible to report any suspected case to the health facility. A team from the health facility visits the village and detects cases, reports to our field office in Urozgan or regional office in Kandahar. With logistical support of MSF, an assigned team of AHDS investigates further and takes action against the disaster. Special focus is on outbreaks of watery and bloody diarrhea, malaria, typhoid fever, polio, meningitis, viral hepatitis, whooping cough and measles.

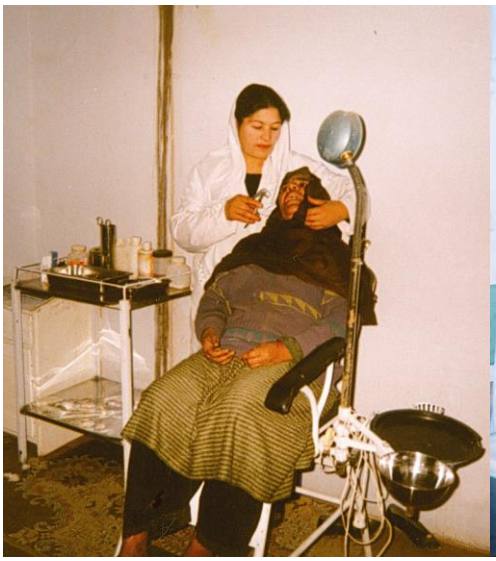


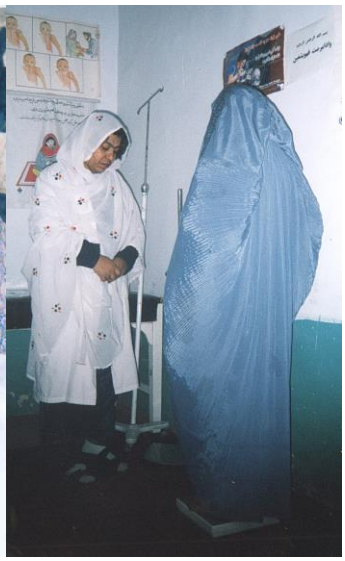



The following outbreaks were reported during year 2002:

- 191 cases of Pertussis reported on April 21st from Shahwalikote, Kandahar
- 49 cases of Typhoid fever reported on May 2nd from Panjwaie, Kandahar
- 2 cases of Meningitis reported on July 24th from Karz, Kandahar
- 10 cases of Pertusis reported on August 20th from Daman, Kandahar
- 60 cases of suspected Cholera reported on September 16th from Dehrawood, Urozgan
- 44 cases of suspected Cholera reported on September 18th from Tirinkote, Urozgan
- 4 cases of suspected cholera reported from Chora in October
- 46 cases of suspected Cholera reported on November 15th and 29th from Dehrawood, Urozgan
- 7 cases of Polio reported from different locations through out the year (3 cases confirmed)

AHDS' mobile health teams have detected cases in the villages, managed cases, referred severe ones to health facilities, vaccinated children if required, and chlorinated water sources.





# Reproductive Health

Health of women, especially mothers, has been at the top of AHDS' priorities. Health of mothers will insure healthy children, healthy families and a healthy future for Afghan communities. Nevertheless, lack of female human resource is very obvious in rural areas and general living conditions and security is not appropriate to attract them from cities. Even with these limitations, AHDS was able to provide relatively good access to women in the target areas. 37.8% of patients treated in the clinics were women (124,527), tetanus vaccine (TT1) was provided for 20,076 childbearing age women out of whom 15,439 received a second dose (TT2 coverage 12.3%) and supplementary food and micronutrients were distributed to pregnant and lactating mothers. One of the main topics for health education sessions was reproductive health. Breastfeeding, family planning, nutrition, immunization antenatal care and sexually transmitted diseases were topics for discussion.

The nutrition program is a good opportunity for provision of antenatal care and immunization. Considering difficult access to MCH centers (difficult geographic condition: disperse population, hilly ground, lack of roads and transportation means) it is not easy to have all pregnant women attending 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. We are not satisfied by the reported 5,876 antenatal care visits (3,016 first visit, 1,510 second visit and 1,350 third) in year 2002. In addition to it TBAs also had home visits. Permanent skilled female staff and enough access to the remotest areas should be insured.

There were 1890 postnatal care visits during the year. The main postnatal complications reported among women who received treatment in AHDS MCH centers were hemorrhage, perineal trauma, uterine prolapse, anemia, breastfeeding problems and uro-genital infections.

# Basic Emergency Obstetric Care (BEOC)

BEOC was provided through 10 MCH centers. Female doctors and midwives were at disposal of mothers around the clock. The MCH centers are equipped with EOC equipment, laboratory and 5 beds at the district level. In the MCH centers, 270 normal deliveries and 110 abnormal deliveries were assisted during 2002. 11 stillbirth, 6 neonatal deaths and zero mother death is reported this year. In addition, cases of abortion, ante-partum and postpartum hemorrhages were managed in the centers. Provision of clean delivery kits and baby kits by UNFPA and Unicef eased our services.

During the year, 626 cases of abortions, 453 cases of hypertension during pregnancy and 410 cases of sepsis after delivery were treated. These numbers are alarming and require the emphasis of additional means of intervention such personal hygiene and sanitation, balanced nutrition and sound psychosocial ambient in addition to the provision of EOC in order to keep mothers away from risky practices and decrease maternal mortality rates.

# Family Planning

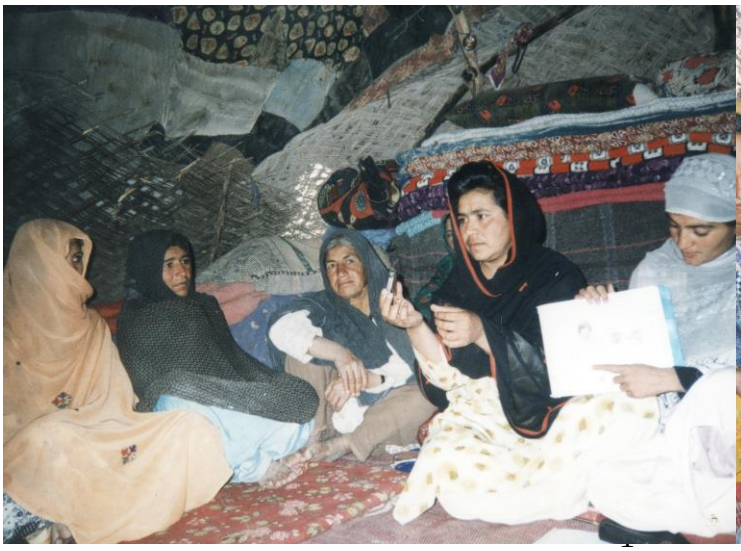
Keeping in mind that Afghanistan has the highest maternal mortality rate (1,700/100,000) and infant mortality rate (165/1,000) in the world, and that women's access to reproductive health care is very low, therefore it is too early to discuss the role of the three delays module (1. decide to seek care, 2. reach medical facility and 3. receive adequate treatment) here, the problem should be approached from multi-directions. The obvious solution for decreasing the maternal mortality rate is provision of EOC. Additional factors that will also contribute in decreasing the rate of the maternal mortality are safe environment, nutrition, education, and family planning. Through EOC we treat the women who are at risk and through family planning we prevent women from going into risk. Although, speaking about limited number of children is not widely acceptable with the current cultural and religious believes in Afghanistan, we can still easily advocate for birth spacing. It is an optimistic sign that contraceptive prevalence rate was raised from 0.71 in 2001 to 3.06 in 2002 in Kandahar and Urozgan provinces, which are conservative areas of the country. Total number of users for different methods of family planning was 3,784 at the end of 2002. The staff of our MCH centers and TBAs have done a great job in raising awareness of couples regarding the value of family planning (21,773 individuals).

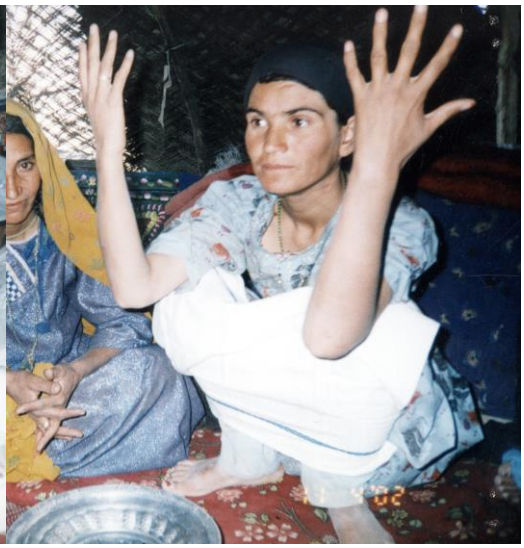
Number of users for safe period has prominently increased (2,902) during the last year, however other methods like depot progesterone (716), oral contraceptive pills (1,810 strips) and male condoms (468) have stayed the same as 2001.

# Role of Traditional Birth Attendants (TBAs)

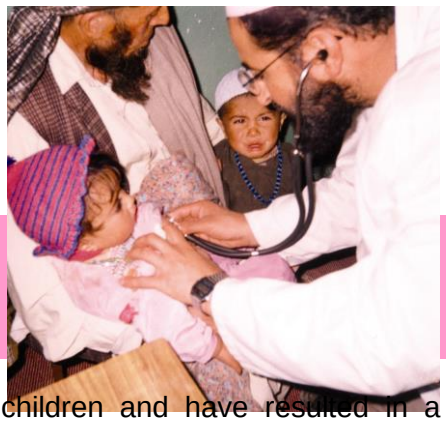
Traditional birth attendants (TBAs) have played a key role in reproductive health for the places where lack of skilled attendants and even literate women is very obvious. They are the ones traditionally helping mothers during delivery and giving advice in cases of health problems. This year a total of 91 TBAs were newly trained in Sperwan, Marghar, Tulukan, Mushan, Nalgham and Karz villages. AHDS has a network of 1,061 trained TBAs who receive refresher training and regular supply and supervision. 9,524 home visits, 5,957 assisted deliveries, and 266 referrals of at-risk mothers to MCH centers is a good indicator of the TBAs value to the communities they work in.

As mentioned in the executive summary, most of our female staff was lost to the urban areas and international agencies; therefore, we could not succeed to train the planned number of new TBAs. However, our existing TBAs were regularly supervised and re-supplied bi-monthly. Input of UNFPA (provision of TBA kits) is worth mentioning here.

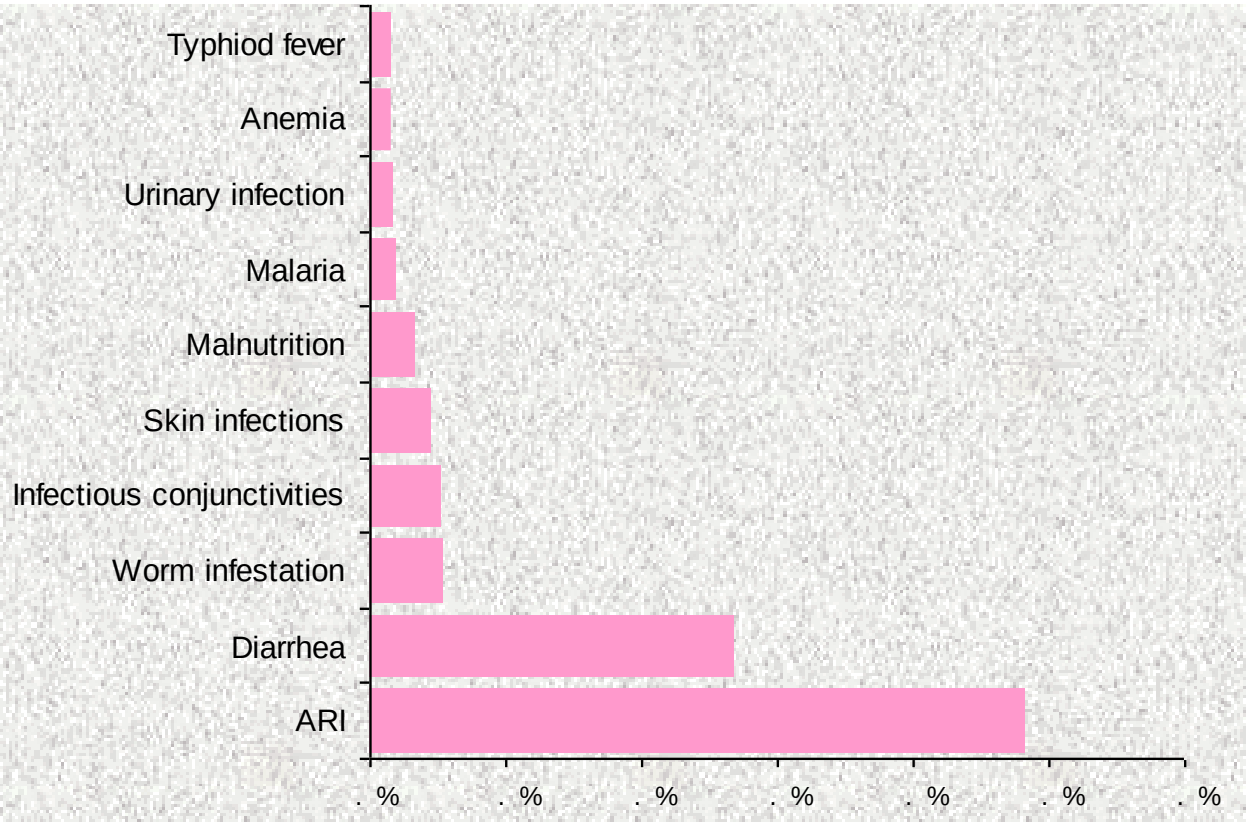




# Childcare



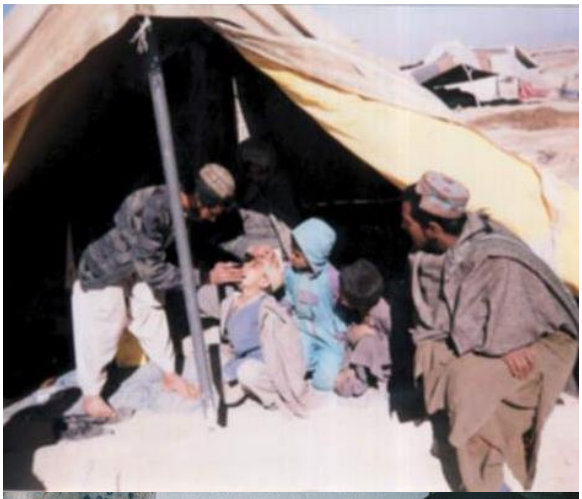
As mentioned in our overall objective, AHDS' main focus is on health of children and women. Besides social mobilization for consideration of children and their health, immunization, nutrition and treatment of childhood illnesses continued to be our mandate. Afghan children are suffering from low quality living conditions, malnourishment, and inadequate access to health and educational opportunities. These conditions have clearly affected the health of children and have resulted in a vicious circle of infection and weakness. High prevalent diseases reported among less than five years children in year 2002 were ARI, diarrhea, malnutrition, parasites and skin and eye infections. Measles, malaria and polio are not eradicated in Afghanistan. AHDS spent 41.6% of its medical care on health of children (total children treated in year 2002: 137,031).

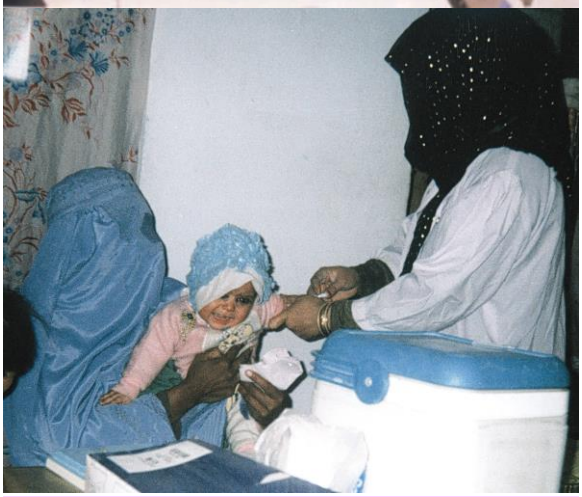



Children's top ten diseases reported from AHDS facilities in 2002

# Immunization

Primary health care is the best opportunity for integration of the current vertical expanded program of immunization (EPI) in Afghanistan. EPI is a vertical program run by MoH and Unicef at national level and integrated to AHDS health centers and sub-centers in target areas. In AHDS health facilities 11 EPI centers were functional in the first half and 15 in the second half of year 2002. AHDS provided incentive and training for the vaccinators. More than 100,000 shots of vaccines were applied to children from the EPI centers this year. In comparison to the previous year and the goal we had planned routine immunization coverage went down in 2002. One cause was frequent National Immunization Days (NID) and Sub-NIDs. At each NID our whole resources (manpower and supplies) were busy for long periods (preparation, refresher trainings, implementation, reporting, follow up…), therefore less attention was given to routine vaccination. Although the issue of National policy for boosting up the routine coverage has been raised few times by different health agencies, but considering the current difficult situation in Afghanistan the main players could not address the problem efficiently. Although immunization campaign's role is very important for eradication of communicable diseases, but routine immunization available countrywide will result to optimum coverage. Other important reason for low immunization coverage is limited access to the existing EPI centers. Only one center is serving a district. At least in southwest region of Afghanistan districts have big areas with low-density scattered population. Therefore, covering the catchments areas of the center (fixed and outreach) does not mean that the district is covered. Each district will need more EPI centers or appropriate transportation means (outreach is not possible by bike or on foot).





AHDS recorded the following number of cases for EPI targeted diseases in 2002:

| | |
|---|---|
| • Pertussis | 1,309 |
| • Measles | 109 |
| • Pulmonary tuberculosis | 247 |
| • Diphtheria | 9 |
| • Acute flaccid paralysis (Polio) | 7 |
| • Neonatal tetanus | 0 |
| • Tetanus (other) | 0 |

Based on a global initiative and allocation of sufficient resources for polio eradication, there were 5 National Immunization Days launched during 2002 in addition to extra sub NIDs in some selective regions (in Kandahar and Urozgan on March 5-7, July 23-25, December 15-17) with technical support of WHO, UNICEF, Inter National and National NGOs. Furthermore, this year a mass campaign of measles was launched throughout the country for children of 8 months up to 12 years, which was initiated by UNICEF and the counterparts. One of the advantages of NIDs for polio eradication is that the micro-planning exercise launches at district level. There are committees for these micro-planning exercises and the village elders and local technical workforce is directly involved in the process.

# Nutrition

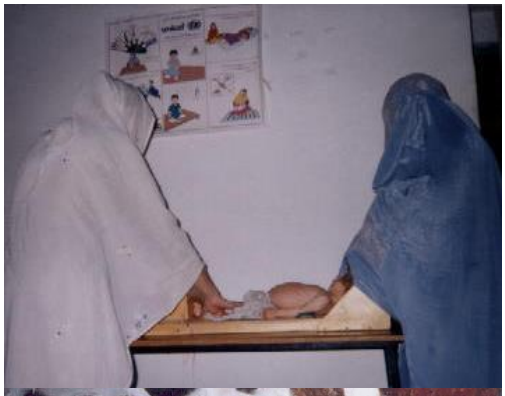
The nutrition status in Afghanistan has been deteriorated as a result of 23 years of continuous conflict and exacerbations of more than five years of drought. The high prevalence of stunted growth (estimated 45-50%) as well as the high prevalence of malnutrition of certain micronutrients is considered a result of the existing food crisis amongst children under the age of five years. (in the context of prevailed more than 40% of protein-Energy Malnutrition (PEM) we didn't understand this part. ). These facts indicate an extremely poor nutritional status of Afghan society and need immediate and prompt intervention. The main reasons for the mentioned facts are population growth, internal displacement and return of refugees, insufficient food stock due to drought, less job opportunity and limited access by humanitarian agencies (health services, food aid, water, and food security).

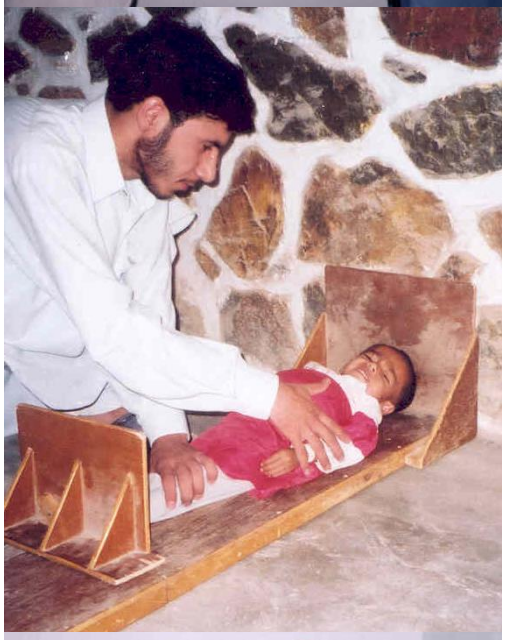
## Targeted Supplementary Feeding

Considering nutrition status of the women and children, its negative impact on health and ability to learn and work, AHDS/Unicef planned to provide them with targeted supplementary feeding. The project was planned to help moderately malnourished women and children. Since the mother and health child health centers are the only and best place for gathering of women in rural areas, the supplementary feeding centers were established in functional MCH centers. The SFP was run through 9 mother and child health centers. The total number of beneficiaries were planned to be 17,952 women and children (9,974 pregnant/lactating women and 7,979 less than five years children) living in the catchment's areas. The project was expected to cover 10% of less than five years age children and 50% of pregnant/lactating women of the catchments areas who could be

malnourished. By the end of the year, we had 6,935 children and 7,989 women enrolling in the program, which means that 87% of estimated malnourished children and 80% of estimated malnourished women are covered by the project.

In total, 175.6 metric tons of foodstuff (133,450 kg WSB, 16,950 kg sugar and 25,218 liter oil) 59,286 vitamin A capsules, 28,000 Folic acid tablets, 840,000 Ferr-Folic acid tablets and 54,686 Mebendazole tablets were distributed. 44 people were trained for running the program (including 20 female and 24 male). 75,197 mothers received health education on nutrition and 20,000 brochures containing information about nutrition/malnutrition was distributed. 906 children and 971 women were successfully discharged after recovery. Average duration of stay was 82 days and average weight gain was 2.6gm/kg body weight/day. The project was warmly welcomed by communities and managed to be beneficial for the women and children. It created a good opportunity to disseminate prime health messages about health and nutrition to the communities. Mothers and children had a better chance to receive consultation of a doctor and follow up as well. The results are good.





## Blanket Supplementary Feeding

AHDS and Unicef considered blanket supplementary feeding for internally displaced people settled in Panjwaie district of Kandahar for three months in the winter. In these IDP camps 84 metric tons of Pre-mix food was distributed to 3,677 beneficiaries; 3,099 children of less than five-year age and 578 pregnant and lactating women (3.8 kg/person fortnightly).

At the last month of the year, AHDS and Unicef agreed upon another project of blanket supplementary feeding for IDPs settled in Panjwaie district and Zeray Dasht. In Zeray Dasht 23,790 IDPs and returnee people are living. Target for feeding project started in December 2002 is 5,498 people: 600 lactating women, 845 pregnant women and 4,053 less than five-year children.

# Water and Sanitation

Water and Sanitation is still one the most prominent problems Afghans are facing. The negative effects of unsafe and shortage of water and unhygienic sanitary practice deteriorate health of communities. The drought has seriously affected our people's socioeconomic life and caused obligatory internal migrations. It is estimated that more than 7 million people have been displaced due to drought in the last 5 years. Based on the mentioned facts AHDS started to pilot a project of water and sanitation in Dehrawood and Trinkote districts of Urozgan in 1999-2000. Being successful in the pilot, and considering the tremendous needs of the communities, another project has been funded by Stichting Vluchteling and UNICEF. Bill and Melinda Gates Foundation had also input to the second project. Started in late 2000, the project continued up to the end of June 2002 (reason for delay was insecurity and slow release of Unicef contribution).

Direct beneficiaries were 42,000 individuals. Achievements of the project were as follows:

- Provided potable water through 300 wells with hand pumps (average one well for 140 people)
- 750 model sanitary latrines (in the villages where wells were provided)
- Local masons trained for making well and latrine
- Community member trained in maintenance/repairmen of hand pumps
- Improved communities' awareness about personal hygiene and sanitation


150 wells in 39 villages of Tirinkote and 150 wells in 13 villages of Dehrawood were provided. The wells are 10 to 45 meters deep (average 15 meters) with at least one-meter water table. 375 latrines in 16 villages of Tirinkote and 375 latrines in 10 villages of Dehrawood were constructed. The criteria of selection according to Sphere Handbook were at least 1 water point per 250 people and maximum distance to the nearest water point 500 meters. Although the plan was provision of 1,500 latrines, according to Sphere one latrine for 20 to 25 people, Unicef accepted only support for 750 models. The latrines are not something usual in the target areas. It is difficult to convince the people to accept and use latrines.

Model sanitary latrines are introduced by AHDS to the people in target areas. The aim was to show what is the use of a latrine, what is its advantages, how is it made and

how it could be used. It is supposed that other families should replicate these models. As a new phenomenon it is not widely accepted and looks rather slow. Therefore, it will take time till the people customize to use latrines and we will be able to introduce better module of safe latrines and waste disposal, in a way that the human waste can be used as harmless fertilizer or fuel.

Even before provision of facilities, it was very important that people understand the necessity and values of hygiene and sanitation. The hazards and risks of carelessness, and non-hygienic practices were brought to people's attention and they were shown how to avoid it. What facilities could enhance healthy practice, how they can adapt it to their own lifestyle. Safe water sources, water collection, preservation and usage were thought to them. Personal hygiene especially for children has been emphasized. Environmental sanitation and waste disposal were taught to the people. The families were encouraged to replicate the models of sanitary latrines in their own houses.

Community participation was the base of our water and sanitation project. The people played important role in communicating with local authorities, site selection, construction and maintenance of the facilities (provision of locally available construction material like sand, gravel, rock and mud bricks and unskilled labor). Volunteers were trained for taking care and repairing of hand pumps and equipped with a small kit of tools. In addition, the project was a good opportunity for the masons and other laborers to learn how to make well and latrine in accordance to the preventive health standards.

# Internally Displaced People (IDP)

At the time of war against terrorism by USA, almost all aid agencies left Kandahar Province, the center of Taliban. AHDS was one of few agencies functioning continuously. The IDPs settled in Panjwaie and Maywand, were left without any support. Therefore, AHDS performed a quick needs assessment in the area and morally supported the needy vulnerable people in the second week of October 2001. Finding the problems and needs, we decided to provide the IDPs with basic health, water and sanitation, food and non-food items. The project was originally planned for six months but later on extended for another two months. The idea was to support the people until they can find their way towards a stable living condition there or in their home villages. Return of relief-oriented agencies could be another chance for AHDS to limit its project to provision of health care. At the beginning, the objectives and principles of the project were discussed and coordinated with local authorities, IDP community leaders, representatives from Ministry of Planning, Ministry of Immigrant's Repatriation, Ministry of Rural Rehabilitation and Development (MRRD) and the aid community. The direct beneficiaries were initially 3,625 and lately 4,500 internally displaced families living near to the Arghandab riverbank in Panjwaie and Maywand districts. Four years back, the river had enough water but dried up since there was no rainfall in recent years. The camps were located in Tulukan, Meshan and new Marghar (people shifted from Mola Dost and Pashmol camps) villages of Panjwaie District and Farzad baba, Qala-e-Shah meer,

**Out Puts:**

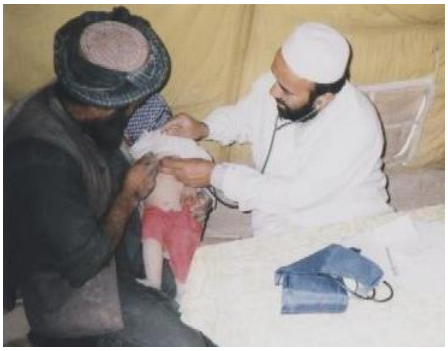
- Foodstuff: totally 469 metric-tons food was distributed for the IDP in Panjwaie and Maywand districts. In the first 5 months the beneficiaries were 3,625 families in first two months, 4,061 families in second 3 months and 4500 families in the last 3 months. The food items were red beans 10 kg/family and edible oil 4 kg/family.
- Non-food items: distributed 4,500 pressure cookers (one for each family), 3000 jerricans (one for each family) and 67,040 bars of soap (2 pieces per family per month).
- Basic health care was provided for the IDP in Panjwaie Dist:
  - Treated patients 22,624; including 10,645 children, 9,393 women and 2,586 men
  - Health education for 19,569 individuals
  - Tetanus vaccine for 1,572 women
  - 6 EPI targeted vaccine for 3,854 children
  - 45 traditional birth attendants were trained for safe birth assistance practices and health education.
- 19 water sources were provided for Panjwaie IDP (16 wells in Marghar, 1 in Meshan and 2 in Tulukan camps).
- A water tanker was hired to provide 8,000 to 16,000 liters water per day for Meshan camp.
- 261 latrines and bathrooms (initially planned 250) were provided for three camps of Panjwaie: Marghar, Tulukan and Mushsan

Miram Khor, Deh Qubad and Madozai villages of Maywand District. The total population was estimated about 30,000 people. They were displaced due to drought 4 years ago from Raig District located in south of Kandahar, which is almost completely evacuated. These are mainly Baluch tribes and smaller number of Pashtoon families. Since the poppy ban there is no job opportunity for these people so they are totally bound on external relief operations.

The distribution teams (food and non-food items), with cooperation of community members, could manage to reach every family. The mobile health team consisted of male and female staff visited the IDPs 6 days a week. The basic health care including immunization, health education, reproductive health and treatment of common diseases were provided. 45 traditional birth attendants (TBA) were trained to help the mothers.

Water supply was started by water-tanks at the beginning, and later on wells, latrines and bathrooms were provided in the camps. The provided covered wells, equipped with hand pump, are 15 to 45 meters deep. AHDS' engineering department designed a new model of portable steel latrine and bathroom that is easy to make and handle, durable and comfortable. It is private enough, culturally sensitive, especially for Afghan ladies. A 5 cubic meters' pit is dug under each ventilation-improved pit latrine.

The project ended successfully; the goal was achieved more than 90%. The supply of food items as well as non-food items such as soap and pressure cookers and the provision of health services were in concordance to the explicit needs of the IDPs. Health education and TBAs training seems a significant intervention for health promotion and early detection of certain reproductive health problems amongst needy and at-risk women of the IDP camps. Provision of health services through mobile health team, early diagnosis and referral services by an ambulance, has decreased the case fatality and consequently resulted in reduction of mortality and morbidities. AHDS' advocacy and coordination resulted to division of tasks. Therefore, IbnSina took responsibility for provision of basic health care and water and sanitation for IDP in Maywand District, and Southwest Afghanistan and Baluchistan Association for Coordination (SWABAC) became responsible for distribution of wheat flour.

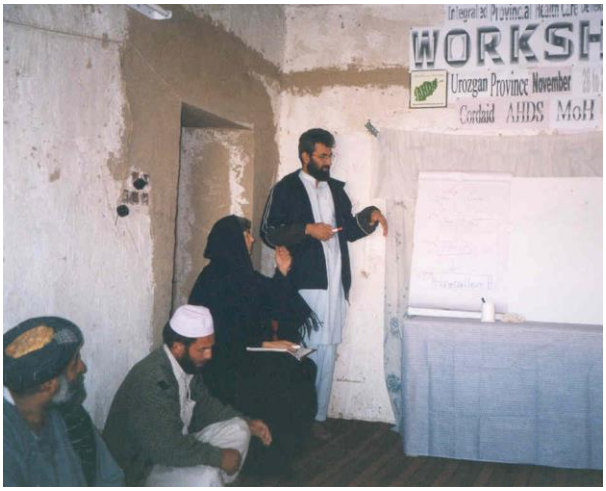



# Capacity Building

New era of Afghanistan rehabilitation is started by the new political changes. We are faced with tremendous work. Both manpower and money are main factors to achieve the goals. Not only AHDS, but also all organizations were faced with high turnover of staff this year. Hence the need for capacity building is intensified now for sustainability of both the organization and the program. In addition, dramatic changes in the field need availability of competent manpower locally. AHDS has considered capacity building at community level, field staff and managerial staff. Also for training opportunities in AHDS Regional Training Center, in other agencies and abroad were used.

Six top managerial staff participated in 11 training workshops out of AHDS (Italy, Pakistan and Kabul). 45 field staff benefited from training opportunities with other health organization including ministry of health in Kabul and Kandahar. AHDS training center provided 8 initial courses, 9 refresher courses and 29 seminars and workshops for 662 people (325 females and 337 males). The participants were mainly from AHDS but some from other health agencies and Ministry of Health (MoH).

Trainings are based on needs assessment among the staff and then looking to existing opportunities. The trainees of AHDS training center were followed up for changes in their performance during practice.



## Main activities of RTC carried out in 2002:

| MONTH | KIND OF TRAINING | COURSE DAYS | COURSE NUMBER | PARTICIPANTS | | |
|---|---|---|---|---|---|---|
| | | | | PROFESSION | NUMBER | |
| | | | | | ♀ | ♂ |
| Feb | CHW refresher seminar (Pneumonia, URTI) | 1 | 1 | Community Health Workers (CHW) | | 25 |
| | PHC orientation workshop | 2 | 1 | Different health categories | 5 | 9 |
| | Literacy course | 90 | 1 | Guard and Drivers | | 3 |
| Mar | CHW refresher course | 6 | 1 | CHWs | | 5 |
| | Nutrition orientation workshop | 1 | 1 | Different health categories | | 8 |
| | TBA trainer Refresher Course | 6 | 1 | Trainers for Traditional Birth Attendant | 10 | |
| | Emergency preparedness workshop | 1 | 1 | Different health categories | | 21 |
| | TBA training | 18 | 1 | TBA for IDPs in Panjwaie | 15 | |
| Apr | Nursing refresher course | 6 | 2 | Nurses | 8 | 7 |
| | EOC workshop | 2 | 1 | Female doctors | 5 | |
| | TBA training | 17 | 1 | TBA for IDPs in Panjwaie | 15 | |
| May | CHW refresher course | 6 | 1 | CHWs | | 5 |
| | Health educator refresher course | 6 | 1 | Health educators | 4 | |
| | UTI workshop | 2 | 1 | Doctors and Mid-Level Health Workers | | 11 |
| | Emergency Preparedness workshop | 1 | 1 | Different health categories | | 14 |
| | 3rd trimester& Postpartum Bleeding workshop | 1 | 1 | Different health categories | 8 | |
| | TBA training | 17 | 1 | TBA for IDPs in Panjwaie | 15 | |
| Jun | Control of Diarrheal Diseases workshop | 2 | 2 | Different health categories | 10 | 16 |
| | HIS workshop | 1 | 1 | Different health categories | 10 | 16 |
| Jul | Nutrition/malnutrition | 2 | 1 | Different health categories | | 4 |
| | EPI plus workshop | 2 | 2 | Vaccinators | 7 | 13 |
| | Nutrition supervision workshop | 2 | 1 | District Health Officers | | 11 |
| | Medical problems during pregnancy | 2 | 1 | Different health categories | 8 | |
| | TBA training | 18 | 1 | TBA, Panjwaie District | 15 | |
| Aug | Health system management workshop | 2 | 1 | Different health categories | | 19 |
| | Nutrition/malnutrition | 2 | 1 | Different health categories | 13 | |
| | Health education course | 3 | 3 | Health Educators | 88 | |
| | CHW refresher course | 6 | 1 | CHWs | | 8 |
| | TBA training | 18 | 1 | TBA, Panjwaie District | 15 | |
| | PHC management | 10 | 1 | Doctors from AHDS and other health agencies | | 20 |
| Sep | HIS+MIS workshop | 2 | 1 | Different health categories | | 15 |
| | Family Planning workshop | 2 | 1 | Different health categories | 9 | |
| | Lab technician refresher course | 6 | 1 | Laboratory Technicians | | 12 |
| | CHW refresher course | 6 | 1 | CHWs | | 8 |
| | Malaria refresher course | 3 | 1 | Laboratory Technicians | | 4 |
| | TBA training | 18 | 1 | TBA, Dand District | 16 | |
| Oct | Health education course | 10 | 1 | OXFAM Health promoters | 7 | 6 |
| | Nutrition surveillance and treatment of acute malnutrition | 5 | 1 | Staff of Supplementary Feeding Center | 15 | 6 |
| | Poisoning workshop | 2 | 1 | Doctors and Mid-Level Health Workers | | 17 |
| | PHC management | 10 | 1 | Doctors from AHDS and other health agencies | | 10 |
| Nov | Integrated Provincial health care development workshop | 2 | 1 | High level managers of AHDS, IbnSina, Cordaid, Ministry of Health and other health agencies in Kandahar | 5 | 23 |
| | Breast Feeding seminar | 6 | 1 | Doctors from AHDS and other health agencies | 22 | |
| D | CHW initial training | 140 | 1 | CHWs | | 21 |
| **Total Participants 662** | | **Female Participants 325** | | | **Male Participants 337** | |

# Management

## Internal management

The main governance of AHDS lies with a Board of Directors, which consists of 2 female and 4 male members. Except for the Director of AHDS, all the remaining 5 members of the current Board of Directors are volunteers. They are working with different organizations (NGOs, UN and Government) with different education and experience background. The founding members have become advisory members of the Board who provide valuable advice and guidance to the organization from time to time. Headed by a Chairperson elected for three-year term, the Board is primarily responsible for policy guidelines and approval of the annual plans, budgets, annual audited financial statements and reports. In addition, the Board is responsible for making changes in the constitution, commencement of new activities, establishment of new goals and objectives and dissolution of the organization as and when needed.

All development and relief operations in AHDS are directed and supervised by the AHDS Director who is responsible for the efficient and effective functioning of the organization according to the constitution. A management team consisting of Deputy Director, Medical Coordinator, MCH Coordinator, Finance Manager, Admin Manager and Project Coordinator assist him. The Main Office houses senior level management of the organization and plays an important role in donor and inter-agency coordination, planning, periodic supervision and evaluation of programs. Data processing, analysis and reporting (both technical and financial), balk procurement and overall financial management are also the responsibilities of the Main Office.

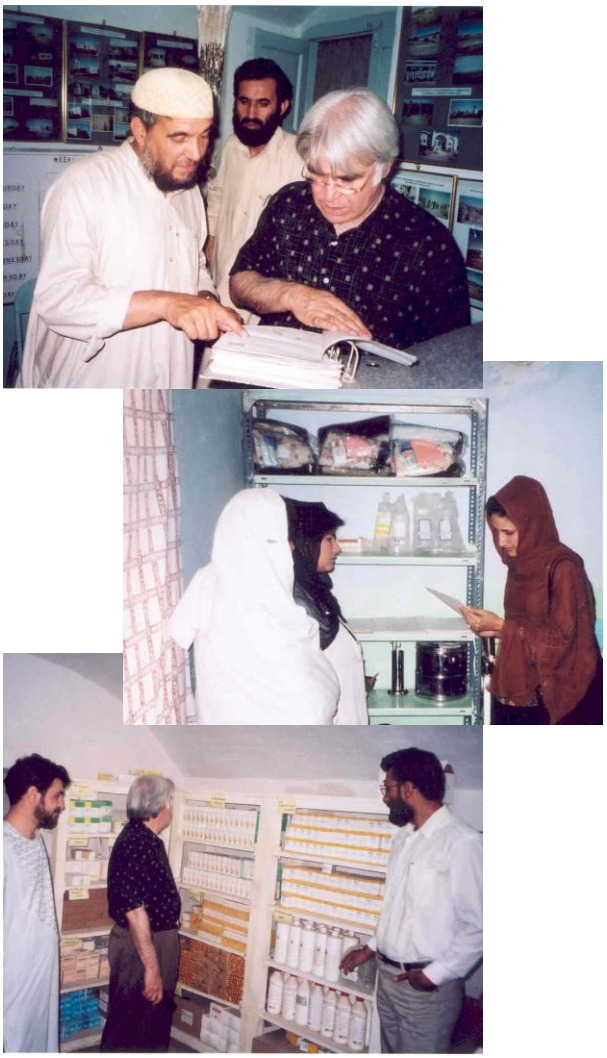
The Regional Office currently located in Kandahar, since 1994, has the main responsibility of coordinating and overseeing all field activities of AHDS in the two provinces. At the Regional Office level, the Regional Coordinator is responsible for the implementation of the project, recruitment of local staff, needs assessment of the area, contact with local authorities, coordination with other agencies in the region, identifying staff members training needs, on-site supervision and monitoring of personnel, data collection, procurements and financial control. The Regional Office directly oversees the operations in Kandahar while the operation in Urozgan is coordinated and supervised by a Field Office in Urozgan. The Field Office reports to the Regional Office and the Regional Office directly reports to the Main Office.

AHDS emphasis on decentralized management and teamwork. Constructive criticism and recommendations have been considered. Staff capacity building and raising up to managerial level is common practice. Regulary monthly meetings were followed by all categories involved in management (main office, regional office, district health officers, MCH officers). In Total 367 staff including 54 females were serving the people in year 2002. As mentioned before the major constraint was attraction of staff to urban areas and high paying international agencies, we had 41 female and 29 male vacancies.

# Monitoring & Supervision

All the projects were monitored regularly by AHDS Director, management team, Training and Supervision section, Engineering department, Health Information System (HIS) section and Pharmacy. Progress of projects was checked up qualitatively and quantitatively comparing to the plans.

Besides the AHDS officials, representatives from partner agencies also have visited the projects few times (Ministry of Health, Ministry of Planning, Cordaid, Unicef, WHO, MSF, AMDA, HNI, HTAC, Mercy Corps) and other interested agencies as well e.g. Management Health for Science (MSH) and Groupe Urgence Rehabilitation Development (URD).



Unicef reports about AHDS as follows:

1.Unicef Assessment of Services and Human Resources Need for the Development of the Safe Motherhood Initiative in Afghanistan (page 43)

"Since 1990 AHDS has been developing sustainable primary healthcare facilities in Afghanistan. Currently, they operate 38 primary healthcare facilities (10 MCH units) in two provinces (Kandahar and Urozgan). In addition, they have a functioning clinical training program for midlevel providers (TBAs, midwives, CHWs, etc) operating out of their main administrative office in Kandahar. This office also houses their central storeroom and a training center.

The central storeroom is located in a well – ventilated, temperature controlled (about 21 Celsius) dry cellar. The storeroom is clean, well-organized, fully stoked and meticulously maintained. The logistics manager has developed a computerized logistics and supply system. The training center is clean, adequately ventilated and illuminated, has the basic equipment (chalkboard, overhead projector, and screen), and has seating for about 12-15 students around a conference table. Dormitory accommodations are available on site for both women and men. AHDS staff provides short- courses RH training as well as logistics and supply and management training, not only for their staff, but also for staff other NGOs in the region as well. In addition, the MCH clinic in Kandahar has a small clinical training unit with dormitory space for of 4-6 midwifes, TBA or female CHWs and their children. This unit is specifically used for basic EmOC training.

We visited two AHDS MCH units, one located in Kandahar City, the other in Maiwand, a 1- hour drive west of Kandahar, just off the main road to Grishk. Both were clean, well-staffed and organized, busy and had midwives, TBAs and a female physician. Basic EmOC services are provided during the daytime at present but soon will be available on a 24/7 basis. As was the case in the Northern region, each MCH clinic is linked to a network of TBAs. In the AHDS system, however, TBA services are regularly monitored and 1-3 day short courses are conducted at frequent intervals for knowledge updates and skill training as well as for new TBA provider training. Again, as in other regions the number of deliveries per month was low (less than 20-25) at each facility while antenatal services were heavily utilized (50-60 per day). Disposal of biohazard us waste is burning and then burying the ash."

2.Safe Motherhood Needs Assessment (CDC/UNICEF Afghanistan 2002, page 49):

> "AHDS has two training units in Kandahar, as well as living accommodations for both women and men. Because community-level midwifery training is a priority for the region, a program similar to that being set up in Eastern Region by HNI could be established. Therefore, consideration should be given to having AHDS develop the program, in collaboration with HNI or another appropriate partner, and manage it until such time that the nursing school (MoH) is capable of running it."

# Coordidnation and Cooperation

AHDS actively participated in the workshops and working groups initiated by Ministry of Health or any other organization aimed towards rehabilitation of health infrastructure and health status at national and regional level. AHDS is member of Afghan NGOs Coordination Bureau (ANCB) and Afghan Coordinating Body for Afghan Relief (ACBAR). AHDS had active inputs as a member of ACBAR steering committee, National Technical Coordination committee (NTCC), national task forces lead by MoH (HIS, Community Based Health Care, MCH, Nutrition and the Health Education). Furthermore, at regional level AHDS is a member of Health Coordination Committee, Regional EPI Management Team, provincial EPI management team (PEMT), Regional Malaria Control Subcommittee and the Water and Sanitation Subcommittee.

Cooperation and partnership of AHDS with Ministry of Health, Unicef and Health Net International in provision of nutrition, immunization and control of malaria were valid examples of our believe in joint efforts to bring changes. Physiotherapy centers for disabled supported by Comprehensive Disabled Afghans' Program (CDAP) from UNDP was integrated in two Comprehensive Health Centers of AHDS. The projects were coordinated among NGOs and UN agencies functional in our target areas. An example is handing over the Comprehensive/mother and child health center, located in Keshkenakhud of Maywand District, to IbnSina (another Afghan NGO). AHDS committed its-self to manage 3 health facilities in the locations where IbnSina evacuated (in Arghandab and Dand districts). We are in the process of building up an Integrated Provincial Health Care Development with Ministry of Health, IbnSina and Cordaid.

In addition to the project agreements, extra contributions to enforce our Primary Health Care project were kindly pledged by respected organizations like the Association of Medical Doctors of Asia (AMDA), World Health Organization (WHO), United Nations Populations Fund (UNFPA), United Nations Children Fund (UNICEF), International Organization for Migration (IOM) and AmeriCares through Help the Afghan Children (HTAC).

Maywand, a partially ruined MoH clinic, was rehabilitated and activated in December 1998 by AHDS. It was handed over to IbnSina in year 2002.

# Community participation

Community mobilization and participation have been the key issue for any project implemented by AHDS. The communities were involved both in needs assessment and implementation. We are seeking to find ways to enable the communities for active involvement in planning, management and evaluation process as well. Our vision is to decrease dependence on external aid and reach self-sustainability with support from our own communities.

The Community Health Committees, Community Health Workers (CHW) and Trained Traditional Birth Attendants (TBA) had their regular monthly meetings. Through these meetings community members and AHDS have raised their concerns and used the opportunity for awareness and mobilization. Community contribution as fee for consultation was US$ 46,567 this year. In addition, their non-monetary (equal to US$ 11,260) inputs in the projects for assistance to IDPs, water and sanitation and nutrition projects and especially ensuring of security were the most crucial supports.

# Health Information System

AHDS is implementing the national HIS existing formats, which is prepared for OPD (outpatient). Immunization reporting format is also used countrywide. AHDS is a member of the HIS task force in Ministry of Health. The group is working on establishing indicators, proper formats and tools for the Basic Package of Health Services agreed upon by all health agencies and donors. We expect to be able to address all the required aspects of information needed for situation analysis, redirection and future planning of health nationwide.

Respecting the National HIS we report herewith only the Outpatient report and Immunization for our health facilities during year 2002. Our other formats used for HIS (health education, laboratory, MCH activities, early warning system and TBA) are different from other organizations.

| No | CATEGORIES | M; 0-4 | F; 0-4 | M; 5-14 | F; 5-15 | M; >=15 | F; >=15 | TOTAL | RE ATTENDENCE |
|---|---|---|---|---|---|---|---|---|---|
| 1 | **TOTAL OPD VISITS** | 45185 | 37329 | 28549 | 25968 | 67584 | 124527 | 329142 | |
| 2 | ARI; COUGH AND COLD (No Pneumonia) | 6091 | 4969 | 3639 | 3273 | 5973 | 9903 | | 196 |
| 3 | ARI; ENT | 8946 | 7089 | 5711 | 5285 | 6139 | 9696 | | 300 |
| 4 | ARI; PNEUMONIA | 6292 | 4693 | 1910 | 1450 | 2081 | 2399 | | 290 |
| 5 | COPD&ASTHMA | 1884 | 1454 | 1839 | 1695 | 6131 | 7978 | | 115 |
| 6 | HYPERTENTION | 180 | 146 | 59 | 85 | 1303 | 3988 | 5761 | 186 |
| 7 | ACUTE WATERY DIARRHEA | 7874 | 6163 | 2266 | 1897 | 3441 | 3861 | | 168 |
| 8 | ACUTE BLOODY DIARRHEA | 7659 | 5981 | 2699 | 2145 | 5386 | 4857 | | 263 |
| 9 | PEPTIC DISORDERS | 53 | 87 | 542 | 978 | 8196 | 18386 | 28242 | 445 |
| 10 | WORM INFESTATION | 1587 | 1399 | 2500 | 2029 | 2066 | 1393 | 10974 | 70 |
| 11 | VIRAL HEPATITIS | 32 | 14 | 27 | 29 | 73 | 56 | 231 | 1 |
| 12 | MEASLES | 26 | 12 | 9 | 6 | 0 | 3 | 56 | 0 |
| 13 | PERTUSIS | 238 | 182 | 134 | 78 | 22 | 23 | 677 | 8 |
| 14 | DIPHTHERIA | 2 | 2 | 0 | 0 | 0 | 1 | 5 | 0 |
| 15 | NEONATAL TETANUS | 0 | 0 | | | | | 0 | 0 |
| 16 | TETANUS | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| 17 | ACUTE FLACCID PARALSIS | 0 | 0 | 1 | 2 | 0 | 1 | 4 | 0 |
| 18 | ACUTE MENINGITIS | 2 | 3 | 7 | 10 | 3 | 1 | 26 | 2 |
| 19 | RABIES | 0 | 2 | 2 | 0 | 0 | 2 | 6 | 0 |
| 20 | PULMONARY TUBERCULOSIS | 6 | 3 | 17 | 17 | 42 | 119 | 204 | 7 |
| 21 | MALARIA | 467 | 486 | 797 | 818 | 1432 | 1226 | 5226 | 53 |
| 22 | TYPHOID | 444 | 375 | 788 | 601 | 1168 | 1029 | 4405 | 63 |
| 23 | CUTANEOUS LEISHMANIASIS | 127 | 144 | 130 | 84 | 86 | 99 | 670 | 8 |
| 24 | LEPROSY | 0 | 0 | 0 | 1 | 0 | 0 | 1 | 0 |
| 25 | SCABIES, PYODERMIA, DERMATOPHYTE INFECTIONS | 1743 | 1448 | 2083 | 889 | 1395 | 3149 | 10707 | 124 |
| 26 | TRACHOMA | 28 | 23 | 28 | 419 | 859 | 71 | 1428 | 2 |
| 27 | INFECTIOUS CONJUNCTIVITIS | 2362 | 2084 | 1633 | 1225 | 3508 | 2814 | 13626 | 87 |
| 28 | URINARY TRACT INFECTIONS | 459 | 326 | 755 | 915 | 2360 | 8213 | 13028 | 210 |
| 29 | REPRODUCTIVE TRACT INFECTIONS | 114 | 1 | 6 | 64 | 1141 | 9042 | 10368 | 63 |
| 30 | ANEMIA | 368 | 501 | 724 | 676 | 1228 | 11982 | 15479 | 294 |
| 31 | GOITRE | 15 | 32 | 0 | 3 | 0 | 5 | 55 | 3 |
| 32 | MALNUTRITION; MODERATE AND SEVERE | 2389 | 2125 | 0 | 12 | 19 | 0 | 4545 | 18 |
| 33 | NARCOTICS RELATED PROBLEMS | 2 | 1 | 4 | 0 | 422 | 32 | 461 | 1 |
| 34 | PSYCHIATRIC DISORDERS | 5 | 5 | 20 | 305 | 408 | 1014 | 1757 | 16 |
| 35 | MINE INJURIES | 9 | 21 | 39 | 1227 | 1395 | 34 | 2725 | 15 |
| 36 | OTHER INJURIES/BURNS | 608 | 550 | 1254 | 685 | 8019 | 1532 | 12648 | 80 |
| 37 | OTHERS/UNLISTED DIAGNOSIS | 1566 | 1445 | 1978 | 1108 | 6846 | 25423 | 38366 | 217 |
| 38 | REFERRALS | 327 | 294 | 292 | 156 | 274 | 715 | 2058 | |
| 39 | HYPERTENSIVE DISORDERS DURING PREGNANCY | | | | 0 | | 453 | 453 | 12 |
| 40 | ABORTIONS | | | | 0 | | 626 | 626 | 8 |
| 41 | HEMORRAGE; ANTEPARTUM | | | | 0 | | 113 | 113 | 0 |
| 42 | HEMORRAGE; POSTPARTUM | | | | 0 | | 91 | 91 | 0 |
| 43 | PUEREAL/POSTPARTUM SEPSIS | | | | 0 | | 410 | 410 | 0 |
| 44 | DELIVERIES AT CLINIC; NORMAL VERTEX | | | | 0 | | 270 | 270 | |
| 45 | ASSISTED DELIVERIES AT CLINIC | | | | 0 | | 110 | 110 | |
| 46 | NEWNATES DELIVRED <2500gm | 104 | 75 | | | | 0 | 179 | |
| 47 | NEWNATES DELIVRED =>2500gm | 88 | 80 | | | | 0 | 168 | |
| 48 | STILLBIRTHS | 4 | 7 | | | | 0 | 11 | |
| 49 | NEONATAL DEATHS | 4 | 2 | | | | 0 | 6 | |
| 50 | MATERNAL DEATHS | | | | 0 | | 0 | 0 | |
| 51 | NEW ANTENATAL VISITS | | | | 2 | | 3014 | 3016 | |
| 52 | SECOND ANTENATAL VISITS | | | | 0 | | 1510 | 1510 | |
| 53 | OTHER ANTENATAL VISITS | | | | 0 | | 1350 | 1350 | |
| 54 | POSTPARTUM VISITS | | | | 0 | | 1890 | 1890 | |
| 55 | OBSTETRIC REFERRALS | | | | 0 | | 126 | 126 | |
| 56 | LABORATORY; POSITIVE SLIDES FOR P. FALCIPARUM | 4 | 5 | 11 | 13 | 11 | 15 | 59 | 0 |
| 57 | LABORATORY; POSITIVE SLIDES FOR P. VIVAX | 25 | 33 | 48 | 45 | 54 | 70 | 275 | 0 |
| 58 | DENTAL VISITS | 61 | 67 | 272 | 336 | 2052 | 2767 | 5555 | 180 |

| VACCINATIONS | | Jan | Feb. | Mar. | Apr. | May | Jun. | Jul. | Aug. | Sept. | Oct. | Nov. | Dec. | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Children < 1 year** | | | | | | | | | | | | | | |
| Out-reach | BCG | 283 | 210 | 323 | 594 | 499 | 290 | 401 | 538 | 389 | 354 | 274 | 199 | 4,354 |
| | DPT1 | 264 | 199 | 323 | 589 | 468 | 297 | 398 | 493 | 379 | 337 | 261 | 185 | 4,193 |
| | DPT2 | 260 | 138 | 220 | 333 | 289 | 215 | 258 | 454 | 421 | 319 | 212 | 219 | 3,338 |
| | DPT3 | 222 | 156 | 166 | 308 | 310 | 173 | 261 | 304 | 220 | 333 | 202 | 192 | 2,847 |
| | OPV1 | 272 | 199 | 301 | 581 | 498 | 266 | 397 | 484 | 379 | 337 | 261 | 183 | 4,158 |
| | OPV2 | 215 | 138 | 231 | 832 | 376 | 221 | 246 | 450 | 421 | 329 | 212 | 219 | 3,890 |
| | OPV3 | 222 | 156 | 159 | 343 | 373 | 173 | 261 | 291 | 220 | 334 | 202 | 192 | 2,926 |
| | OPV4 | 37 | 21 | 102 | 114 | 130 | 34 | 75 | 166 | 56 | 57 | 26 | 13 | 831 |
| | Measles | 188 | 151 | 96 | 379 | 306 | 187 | 259 | 344 | 297 | 254 | 236 | 175 | 2,872 |
| Fixed-center | BCG | 504 | 367 | 434 | 584 | 804 | 645 | 707 | 696 | 810 | 719 | 665 | 459 | 7,394 |
| | DPT1 | 498 | 380 | 987 | 595 | 800 | 699 | 689 | 656 | 788 | 697 | 737 | 502 | 8,028 |
| | DPT2 | 341 | 354 | 326 | 368 | 563 | 692 | 578 | 552 | 615 | 542 | 610 | 533 | 6,074 |
| | DPT3 | 276 | 307 | 317 | 284 | 582 | 491 | 527 | 406 | 539 | 429 | 462 | 458 | 5,078 |
| | OPV1 | 497 | 380 | 487 | 589 | 804 | 639 | 689 | 657 | 788 | 626 | 684 | 449 | 7,289 |
| | OPV2 | 341 | 354 | 325 | 368 | 566 | 642 | 578 | 553 | 615 | 462 | 585 | 504 | 5,893 |
| | OPV3 | 276 | 314 | 317 | 277 | 486 | 452 | 527 | 401 | 539 | 370 | 472 | 454 | 4,885 |
| | OPV4 | 211 | 128 | 302 | 150 | 150 | 138 | 162 | 184 | 113 | 107 | 157 | 157 | 1,959 |
| | Measles | 312 | 348 | 243 | 346 | 481 | 496 | 482 | 468 | 506 | 510 | 467 | 452 | 5,111 |
| **Children 1-2 years** | | | | | | | | | | | | | | |
| Out-reach | BCG | 69 | 50 | 64 | 148 | 89 | 46 | 117 | 124 | 82 | 120 | 117 | 49 | 1,075 |
| | DPT1 | 71 | 50 | 60 | 148 | 89 | 95 | 117 | 125 | 79 | 122 | 117 | 49 | 1,122 |
| | DPT2 | 50 | 25 | 79 | 99 | 54 | 36 | 93 | 111 | 69 | 131 | 101 | 50 | 898 |
| | DPT3 | 63 | 49 | 65 | 99 | 40 | 37 | 76 | 103 | 79 | 127 | 75 | 41 | 854 |
| | OPV1 | 71 | 50 | 60 | 149 | 89 | 51 | 117 | 125 | 79 | 122 | 117 | 49 | 1,079 |
| | OPV2 | 50 | 22 | 75 | 102 | 52 | 35 | 84 | 111 | 69 | 127 | 101 | 58 | 886 |
| | OPV3 | 63 | 45 | 64 | 101 | 36 | 37 | 76 | 107 | 79 | 121 | 75 | 48 | 852 |
| | OPV4 | 29 | 0 | 54 | 1 | 0 | 0 | 0 | | 0 | 0 | 0 | 0 | 84 |
| | Measles | 82 | 57 | 31 | 135 | 76 | 55 | 136 | 135 | 102 | 132 | 146 | 46 | 1,133 |
| Fixed-center | BCG | 174 | 84 | 121 | 89 | 115 | 210 | 183 | 149 | 172 | 152 | 113 | 57 | 1,619 |
| | DPT1 | 171 | 123 | 150 | 89 | 115 | 215 | 183 | 150 | 172 | 152 | 128 | 57 | 1,705 |
| | DPT2 | 146 | 104 | 101 | 77 | 72 | 156 | 93 | 89 | 80 | 91 | 69 | 57 | 1,135 |
| | DPT3 | 159 | 161 | 110 | 65 | 81 | 176 | 60 | 71 | 72 | 75 | 59 | 65 | 1,154 |
| | OPV1 | 171 | 124 | 181 | 88 | 115 | 201 | 181 | 129 | 172 | 152 | 144 | 57 | 1,715 |
| | OPV2 | 138 | 99 | 101 | 77 | 72 | 153 | 93 | 89 | 80 | 91 | 88 | 56 | 1,137 |
| | OPV3 | 159 | 153 | 110 | 65 | 69 | 143 | 66 | 71 | 72 | 76 | 69 | 72 | 1,125 |
| | OPV4 | 103 | 108 | 137 | 9 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 358 |
| | Measles | 227 | 208 | 187 | 149 | 129 | 232 | 201 | 155 | 186 | 168 | 166 | 85 | 2,093 |
| **Women 15-45 years, Pregnant** | | | | | | | | | | | | | | |
| Out-reach | TT1 | 95 | 102 | 138 | 256 | 294 | 89 | 135 | 204 | 199 | 178 | 157 | 173 | 2,020 |
| | TT2 | 57 | 76 | 126 | 171 | 263 | 86 | 128 | 206 | 179 | 152 | 133 | 140 | 1,717 |
| | TT3 | 45 | 69 | 74 | 108 | 125 | 49 | 65 | 114 | 74 | 81 | 62 | 73 | 939 |
| | TT4 | 6 | 15 | 22 | 22 | 44 | 26 | 29 | 32 | 12 | 40 | 12 | 14 | 274 |
| | TT5 | 2 | 8 | 8 | 9 | 14 | 4 | 11 | 11 | 4 | 5 | 5 | 4 | 85 |
| Fixed-center | TT1 | 152 | 214 | 328 | 414 | 581 | 570 | 620 | 580 | 637 | 473 | 317 | 403 | 5,289 |
| | TT2 | 141 | 152 | 146 | 243 | 369 | 398 | 426 | 438 | 396 | 393 | 271 | 310 | 3,683 |
| | TT3 | 142 | 97 | 103 | 86 | 169 | 195 | 222 | 171 | 141 | 190 | 96 | 120 | 1,732 |
| | TT4 | 33 | 40 | 47 | 46 | 62 | 40 | 42 | 94 | 44 | 43 | 14 | 55 | 560 |
| | TT5 | 17 | 10 | 9 | 11 | 20 | 18 | 19 | 15 | 8 | 21 | 6 | 16 | 170 |
| **Women 15-45 years, Non-pregnant** | | | | | | | | | | | | | | |
| Out-reach | TT1 | 152 | 146 | 221 | 274 | 378 | 146 | 273 | 281 | 297 | 303 | 188 | 228 | 2,887 |
| | TT2 | 85 | 105 | 202 | 227 | 376 | 171 | 217 | 264 | 263 | 229 | 179 | 143 | 2,461 |
| | TT3 | 105 | 144 | 94 | 136 | 181 | 99 | 110 | 112 | 118 | 104 | 73 | 82 | 1,358 |
| | TT4 | 16 | 33 | 56 | 42 | 65 | 35 | 59 | 32 | 35 | 39 | 10 | 23 | 445 |
| | TT5 | 3 | 11 | 9 | 13 | 20 | 6 | 20 | 13 | 2 | 11 | 4 | 4 | 116 |
| Fixed-center | TT1 | 421 | 368 | 307 | 529 | 777 | 897 | 945 | 1028 | 1135 | 940 | 628 | 729 | 8,704 |
| | TT2 | 277 | 339 | 187 | 337 | 558 | 696 | 684 | 721 | 778 | 807 | 517 | 501 | 6,402 |
| | TT3 | 229 | 232 | 135 | 185 | 325 | 340 | 309 | 321 | 258 | 333 | 232 | 252 | 3,151 |
| | TT4 | 112 | 96 | 80 | 73 | 130 | 139 | 77 | 137 | 88 | 97 | 36 | 107 | 1,172 |
| | TT5 | 70 | 49 | 31 | 27 | 74 | 97 | 51 | 56 | 56 | 40 | 25 | 35 | 611 |

# Finance


Mr. Rahmani, Finance Manager

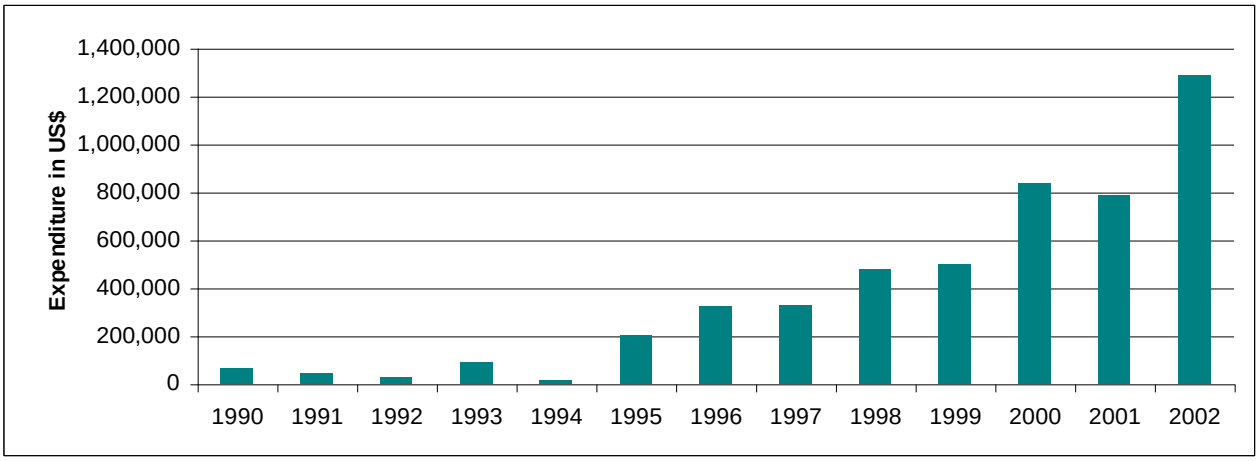
The following table summarizes the donations in hand in the year 2002.

| Donors | In Cash | In Kind | Total | Percent |
|---|---|---|---|---|
| Bill and Melinda Gates Foundation (BMGF) | 235,789 | 0 | 235,789 | 15.0% |
| European Commission (EC) | 407,827 | 0 | 407,827 | 25.9% |
| Cord Aid | 480,000 | 0 | 480,000 | 30.5% |
| Stichting Vluchteling (SV) | 97,884 | 0 | 97,884 | 6.2% |
| UNICEF | 65,774 | 144,690 | 210,464 | 13.4% |
| AmeriCares through Help The Afghan Children | 0 | 52,377 | 52,377 | 3.3% |
| Mercy Corps (MC) | 20,600 | 5,310 | 25,910 | 1.6% |
| WHO | 0 | 2,050 | 2,050 | 0.1% |
| MSF Holland | 0 | 1,190 | 1,190 | 0.1% |
| UNFPA | 0 | 129 | 129 | 0.01% |
| AMDA | 0 | 72 | 72 | 0.01% |
| Community | 46,567 | 11,260 | 57,827 | 3.7% |
| **Total** | **1,354,441** | **217,078** | **1,571,519** | **100%** |

Grants used in year 2002:

| Donors | In Cash | In Kind | Total | Percent |
|---|---|---|---|---|
| Bill and Melinda Gates Foundation (BMGF) | 212,134 | 0 | 212,134 | 16.5% |
| European Commission (EC) | 263,669 | 0 | 263,669 | 20.5% |
| Cord Aid | 436,403 | 0 | 436,403 | 34% |
| Stichting Vluchteling (SV) | 96,647 | 0 | 96,647 | 7.5% |
| UNICEF | 49,135 | 144,690 | 193,825 | 15.1% |
| AmeriCares through Help The Afghan Children | 0 | 52,377 | 52,377 | 4.1% |
| Mercy Corps (MC) | 14,000 | 0 | 14,000 | 1.1% |
| WHO | 0 | 2,050 | 2,050 | 0.2% |
| MSF Holland | 0 | 1,190 | 1,190 | 0.1% |
| UNFPA | 0 | 129 | 129 | 0.01% |
| AMDA | 0 | 72 | 72 | 0.01% |
| Community | 0 | 11,260 | 11,260 | 0.9% |
| **Total** | **1,071,988** | **211,768** | **1,283,756** | **100%** |

Yearly expenditures of AHDS projects:



# M. ALMAS & CO.
CHARTERED ACCOUNTANTS

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MIAN CHAMBERS,
3 – TEMPLE ROAD,
LAHORE – PAKISTAN
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## AUDITORS' REPORT TO

## AFGHAN HEALTH AND DEVELOPMENT SERVICES ( AHDS )

We have audited the annexed consolidated statement of cash receipts and disbursements of the Afghan Health and Development Services as at December 31, 2002 together with the notes forming part thereof (here-in-after referred to as the "financial statements") for the year then ended.

These financial statements are the responsibility of the Management Committee. Our responsibility is to express an opinion on these financial statements based on our audit.

We conducted our audit in accordance with generally accepted auditing standards. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are the free of material misstatements. An audit includes examining on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting policies used and significant estimates made by the management, as well as evaluating the overall presentation of the financial statements. We believe that our audit provides a reasonable basis for our opinion.

As described in note 2.1, the financial statements have been prepared on the basis of cash receipts and disbursement basis of accounting, which is comprehensive basis of accounting other than generally accepted accounting principles.

In our opinion:

(a) the payments made and / or the expenditure incurred during the year was for the purpose of the approved objects of the organization

(b) where funds were received for a specific stated purpose, these have been spent for that purpose only;

(c) revenue reflected in the financial statements is based on the amounts as recorded in the books of account of AHDS. While grants in kind are not included in the financial statements and are accordingly not subject to our audit;

(d) as explained in note 8 to the financial statements, balance at banks Rs.45,050 and Rs.18,468,652 (equivalent US $ 318,151) for Nutrition Project and Primary Health Care Program respectively represent the allocated portion of the balance to these projects and, therefore, could not be independently verified;

(e) cash in hand aggregating to Rs.2,324,518 as at December 31, 2002 could not be independently verified as our appointment was made at a later date;

(f) activities performed in regional offices cannot be substantiated as these could not be visited due to uncertain conditions;

(g) except for the matters referred to in pragraph (c) to (f), the financial statement referred to above present fairly in all material respects, the cash receipt and disbursements of all the projects of Afghan Health and Development Services for the year ended December 31, 2002 on the basis of accounting described in Note 2.1.

April 04, 2003

M. Almas & Co.
CHARTERED ACCOUNTANTS

# M. ALMAS & CO.

CHARTERED ACCOUNTANTS

**STATEMENT OF CASH RECEIPTS AND DISBURSEMENTS - PROJECTWISE**

PRIMARY HEALTH CARE PROGRAM

| | BILL AND MELINDA GATES FOUNDATION | | EUROPEAN COMMISSION AND STICHTING VLUCHTELING (SV) | | NUTRITION PROJECT FUNDED BY UNICEF | | IDP PROJECT FUNDED BY CORDAID | | WATER AND SANITATION PROJECT FUNDED BY UNICEF AND STICHTING VLUCHTELING (SV) | | PRIMARY HEALTH CARE PROGRAM - SPECIAL DONATION FROM MERCY CORPS (MC) | | TOTAL | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | RUPEES | US $ | RUPEES | US $ | RUPEES | US $ | RUPEES | US $ | RUPEES | US $ | RUPEES | US $ | RUPEES | US $ |
| OPENING BALANCE: | | | | | | | | | | | | | | |
| Cash at banks | | | | | | | | | | | | | | |
| - At USA | 13,249,855 | 221,755 | - | - | - | - | - | - | - | - | | | 13,249,855 | 221,755 |
| - At Peshawar | 412,673 | 6,907 | - | - | - | - | - | - | 1,258,130 | 21,003 | | | 1,670,803 | 27,910 |
| Cash in hand | 402,983 | 6,744 | - | - | - | - | - | - | 27,020 | 451 | - | - | 430,003 | 7,195 |
| | 14,065,511 | 235,406 | - | - | - | - | - | - | 1,285,150 | 21,455 | - | - | 15,350,661 | 256,861 |
| RECEIPTS | | | | | | | | | | | | | | |
| Grants | - | | 41,238,813 | 694,866 | 1,500,000 | 25,000 | 23,025,600 | 384,000 | - | - | 813,534 | 14,000 | 66,577,947 | 1,117,866 |
| Interest | 22,850 | 383 | 32,043 | 545 | - | - | - | - | - | - | - | - | 54,893 | 928 |
| Exchange (loss)/gam | (47,131) | | (511,549) | - | (5,446) | - | (74,000) | - | 1,375 | - | - | - | (636,751) | - |
| Total receipts | (24,281) | 383 | 40,759,307 | 695,411 | 1,494,554 | 25,000 | 22,951,600 | 384,000 | 1,375 | - | 813,534 | 14,000 | 65,996,089 | 1,118,794 |
| DISBURSEMENTS: | | | | | | | | | | | | | | |
| Services | 719,499 | 12,075 | 547,417 | 9,187 | 11,066 | 185 | 653,822 | 10,965 | 133,550 | 2,228 | 813,534 | 14,000 | 2,878,888 | 48,640 |
| Equipment and others | 1,262,863 | 21,148 | 2,936,270 | 48,170 | 164,857 | 2,772 | - | - | - | - | - | - | 4,363,990 | 72,090 |
| Supplies | - | - | - | - | - | - | 22,072,759 | 369,880 | - | - | - | - | 22,072,759 | 369,880 |
| Maintenance | 389,604 | 6,517 | 184,760 | 3,099 | - | - | - | - | 1,148,475 | 19,142 | - | - | 1,722,839 | 28,758 |
| Operations | 10,294,755 | 172,394 | 16,155,442 | 274,573 | 2,039,899 | 34,467 | 3,321,988 | 55,558 | 230,539 | 3,862 | - | - | 32,042,623 | 540,854 |
| Administrative cost | - | - | 698,258 | 11,765 | - | - | - | - | - | - | - | - | 698,258 | 11,765 |
| Total disbursements | 12,666,721 | 212,134 | 20,522,147 | 346,794 | 2,215,822 | 37,424 | 26,048,569 | 436,403 | 1,512,564 | 25,232 | 813,534 | 14,000 | 63,779,357 | 1,071,987 |
| CLOSING BALANCE | 1,374,509 | 23,655 | 20,237,160 | 348,617 | (721,268) | (12,424) | (3,096,969) | (52,403) | (226,039) | (3,777) | - | - | 17,567,393 | 303,668 |
| REPRESENTED BY: | | | | | | | | | | | | | | |
| Cash at banks | | | | | | | | | | | | | | |
| - At USA | 1,095,038 | 18,864 | 17,373,614 | 299,287 | - | - | - | - | - | - | - | - | 18,468,652 | 318,151 |
| - At Peshawar | 265,539 | 4,574 | 876,299 | 15,096 | 45050 | 776 | 2,102,703 | 35,578 | (25,694) | (430) | - | - | 3,263,897 | 55,594 |
| Cash in hand | 33,932 | 585 | 2,184,477 | 37,631 | - | - | 2,103 | 35 | 104,006 | 1,737 | - | - | 2,324,518 | 39,988 |
| | 1,394,509 | 24,023 | 20,434,390 | 352,014 | 45,050 | 776 | 2,104,806 | 35,613 | 78,312 | 1,307 | - | - | 24,057,067 | 413,733 |
| Prepayment | - | | 15,900 | 274 | - | - | - | - | - | - | - | - | 15,900 | 274 |
| | 1,394,509 | 24,023 | 20,450,290 | 352,288 | 45,050 | 776 | 2,104,806 | 35,613 | 78,312 | 1,307 | - | - | 24,072,967 | 414,007 |
| Accounts payable | (20,000) | (368) | (213,130) | (3,671) | (766,318) | (13,200) | (5,201,775) | (88,016) | (304,351) | (5,084) | - | - | (6,505,574) | (110,339) |
| | 1,374,509 | 23,655 | 20,237,160 | 348,617 | (721,268) | (12,424) | (3,096,969) | (52,403) | (226,039) | (3,777) | - | - | 17,567,393 | 303,668 |

As stated in note 1 1 to the accounts, grants kind aggregating to Rs.4,667,123 received by AHDS during the year for the Primary Health Care Program are not recorded in the books of account of AHDS. The value of these grants in kind was estimated by the Management Committee of AHDS

DEPUTY DIRECTOR

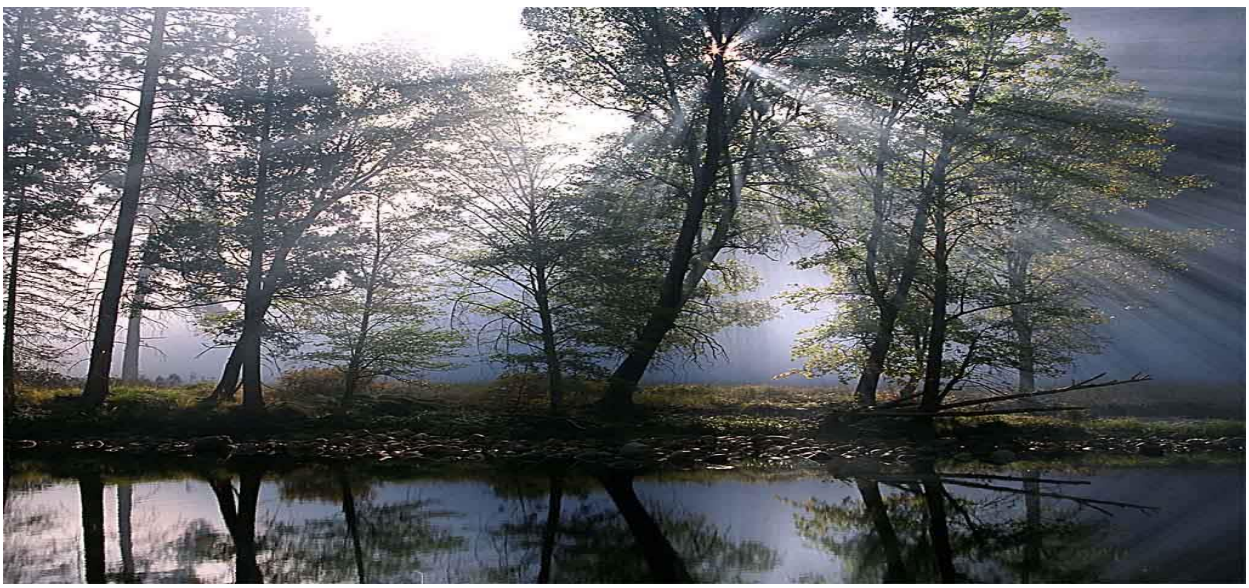
# Women's Day

March 8th was celebrated for the first time in Kandahar by AHDS

# Future Strategy

Afghanistan is just recovered from the long catastrophic fever and needs convalescence period for a while. Its needs are different: emergency relief, washing side effects of mistreatments, empowerment and rehabilitation and development. Afghanistan is on the edge of transition, trembling on a cord moving from emergency relief to rehabilitation and long-term development. The path should be balanced in between two ends, which is not as simple as said. Concentration on one end deteriorates provisions for the other. Requesting the aid community and partners, AHDS as one of the leading national NGOs will strive to carefully step forward and utter its role. Evident closure of education for girls during Taliban regime and practical closure for both boys and girls since longer period has erased readymade values and decreased number of competent Afghans. The situation is exaggerated by brain drains and deaths of our scholars. Therefore, building human resource capacity inside the organization, in the communities and within the government is on the top of our agenda.

AHDS projects has gone in line with previous master plan of Ministry of Health and will adjust its programs according to the National Development Framework, new Health Master-Plan, recommendation from the Joint Donor Mission and Basic Package of Health Services. Attentions will be focused on practical and progressive partnership with community members and government (Ministry of Health). Sustainability of the programs should be sought potentially within Afghanistan and lesser from the outsiders. Steadily, precise stepping-in, building on experience and careful expansion will guarantee gradual and steady development of relations, trust and foreseen impact.



**Special thanks are due to the donors and partners:**

European Commission
Cordaid
Bill and Melinda Gates Foundation
United Nations Children Fund (Unicef)
Stichting Vluchteling
Help The Afghan Children (HTAC)
AmeriCares
Mercy Corps
Medecins Sans Frantieres (MSF)
United Nations Populations Fund (UNFPA)
World Health Organization (WHO)
Health Net International (HNI)
Association of Medical Doctors of Asia (AMDA)
United Nations Development Program (UNDP)
World Food Program (WFP)
International Organization for Migration (IOM)
Ministry of Health (MoH)

كُلُّكُم رَاعٍ وَ مَسؤُلٌ عَن رَعِيَّتِهِ

**الحديث**

**You are all as Pastors and responsible to the ryot**

Al-Hadith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