A Bright New Future

Youth Support Afghanistan

Initiatives for the Restoration, improved Health and Welfare of Afghanistan.

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Youth Support Afghanistan

An Initiative For Restoration And Improved Health in Afghanistan

Project for Hisarak district of Nangarhar Province Afghanistan

Carried out under the auspices of Youth Support in association with 'Humanitarian Assistance & Facilitating Organization (HAFO).

Youth Support is an International NGO founded in 1986 and HAFO was established in 1990 in Peshawar and is an NGO which has been serving Afghanistan with particular reference to farmers and rural initiatives.

Youth support offers experience of setting up health services in several countries and experience in maternal and child welfare; addiction treatment and mental health and general medicine including adolescent issues. Both youth support and HAFO have experience in education and vocational training.

The whole of Afghanistan has significant needs with respect to health and Welfare education and vocational training. Better health and freedom from addiction leads to higher scholastic achievement and a more efficient workforce. These improvements present opportunities for income generation thus improving the productivity and prosperity of the nation.

This document presents an overview of the area and the welfare and health needs of the population.

Introduction

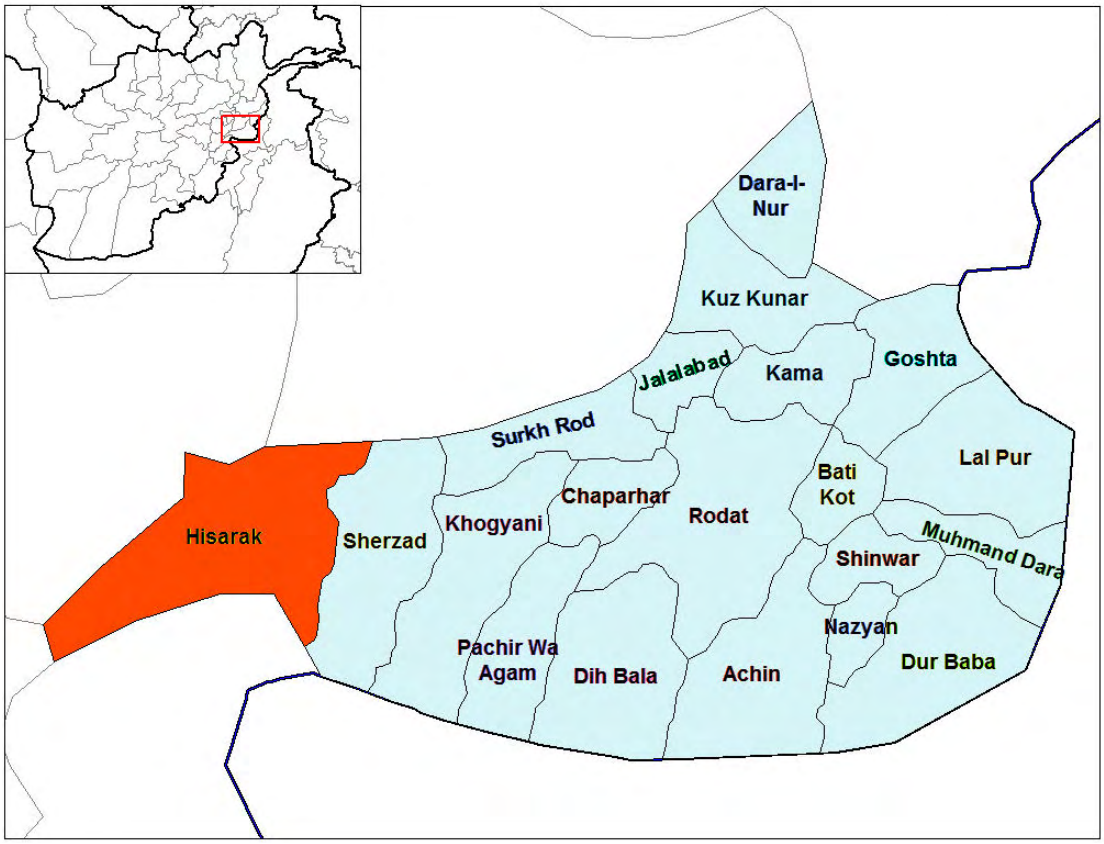
The following Background information has been compiled from the available literature which includes some government statistics and data gathered by the UNHCR and other NGOs.

The quality of the information is not comprehensive and local enquiry indicates that some of the data may be inaccurate. These issues very much underline the necessity to perform baseline surveys and data collection in the area in order to accurately estimate need and plan adequate services. In the meantime the following summarises current available information whilst pointing a way forward.

Background

Description of area and possible problems

Hisarak حصارک is a district in the west of Nangarhar Province, Afghanistan, located 78 km west of Jalalabad city.

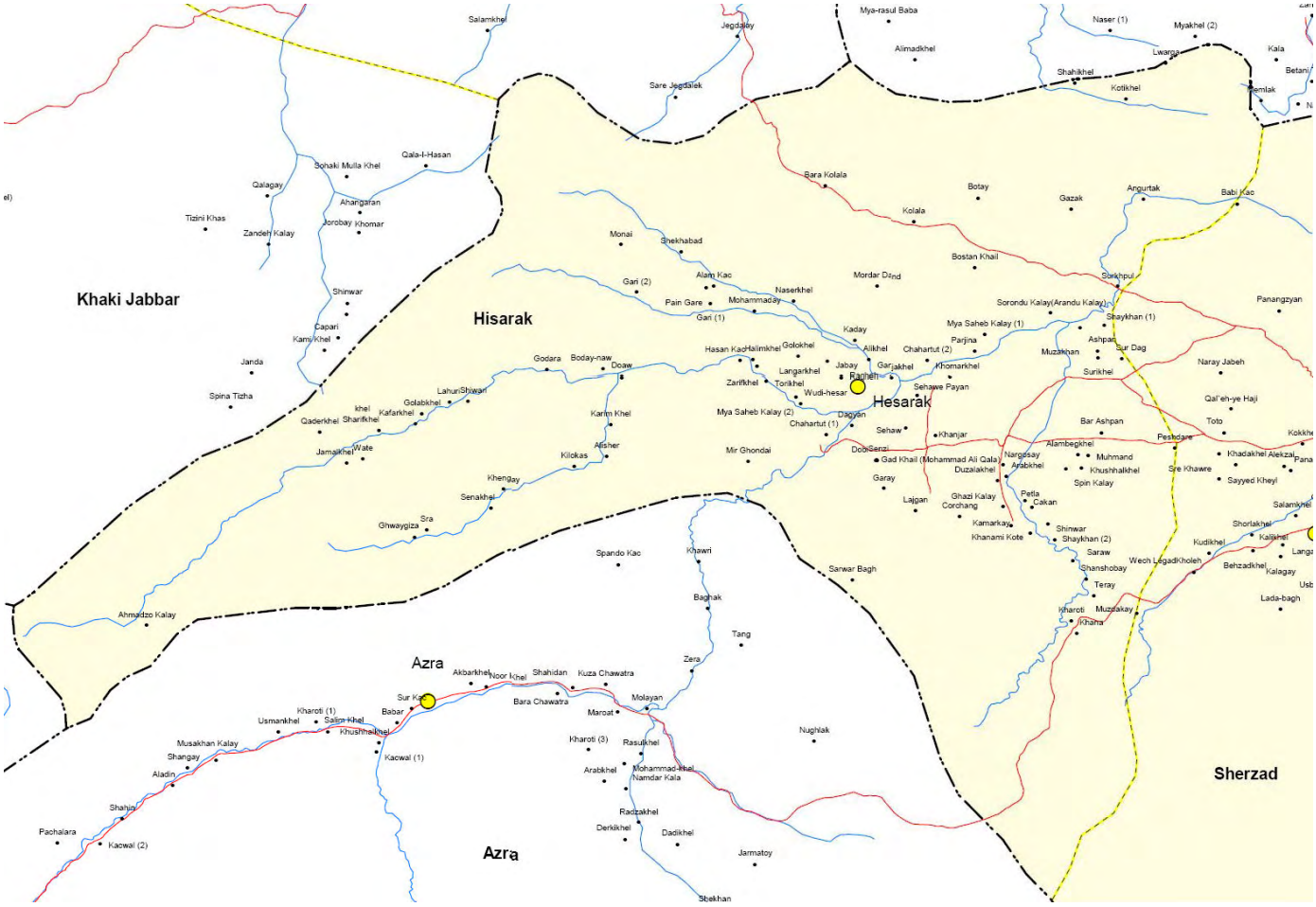


The population which is ethnically Pashtun and Sunni Muslim was estimated at 28,376 in 2002. The 2002 census estimated that 11,380 of the population were children under 12 and hence it is likely that over half the population are under the age of 18 years. {In Afghanistan 14 years is regarded as the age of majority but teenagers aged 12-18 are likely to have particular needs}.

The population is split between 14,464 males and 13,912 females. This is in keeping with the Provincial average of 51% males and 49% females.

The district centre is the village of Hesarak. Which has a population of approximately 10,000

Latitude (DMS):	34° 18' 26 N (34.30722)
Longitude (DMS):	69° 51' 47 E (69.86306)



Nangarhar province consists of mixed terrain of which over half is mountainous or semi-mountainous. Hisarak is surrounded by high mountains and consists of several valleys and 12 major villages located at some distance apart. Each valley is surrounded by mountains, some covered by trees. It experiences cold weather and snow in winter.

The main occupation in the area is farming and crops include wheat, maize and some rice in the low lying areas adjacent to the rivers. There are some unexploited rich mineral deposits in the mountainous areas and the local white marble is highly prized in the UAE and Saudi Arabia.

Many demographic details with respect to Hisarak district and Hesarak village are not recorded and hence it will be essential to gather some baseline information in order to facilitate the planning of restorative services.

Institutional framework

The Institutional framework for the province of Nangarhar is described in the UNAMA Nangarhar provincial Profile which was drawn up in 2007.

The exact implementation of this framework in Hisarak District has not been published and neither have more recent updates to cover the period to the present time (2011).

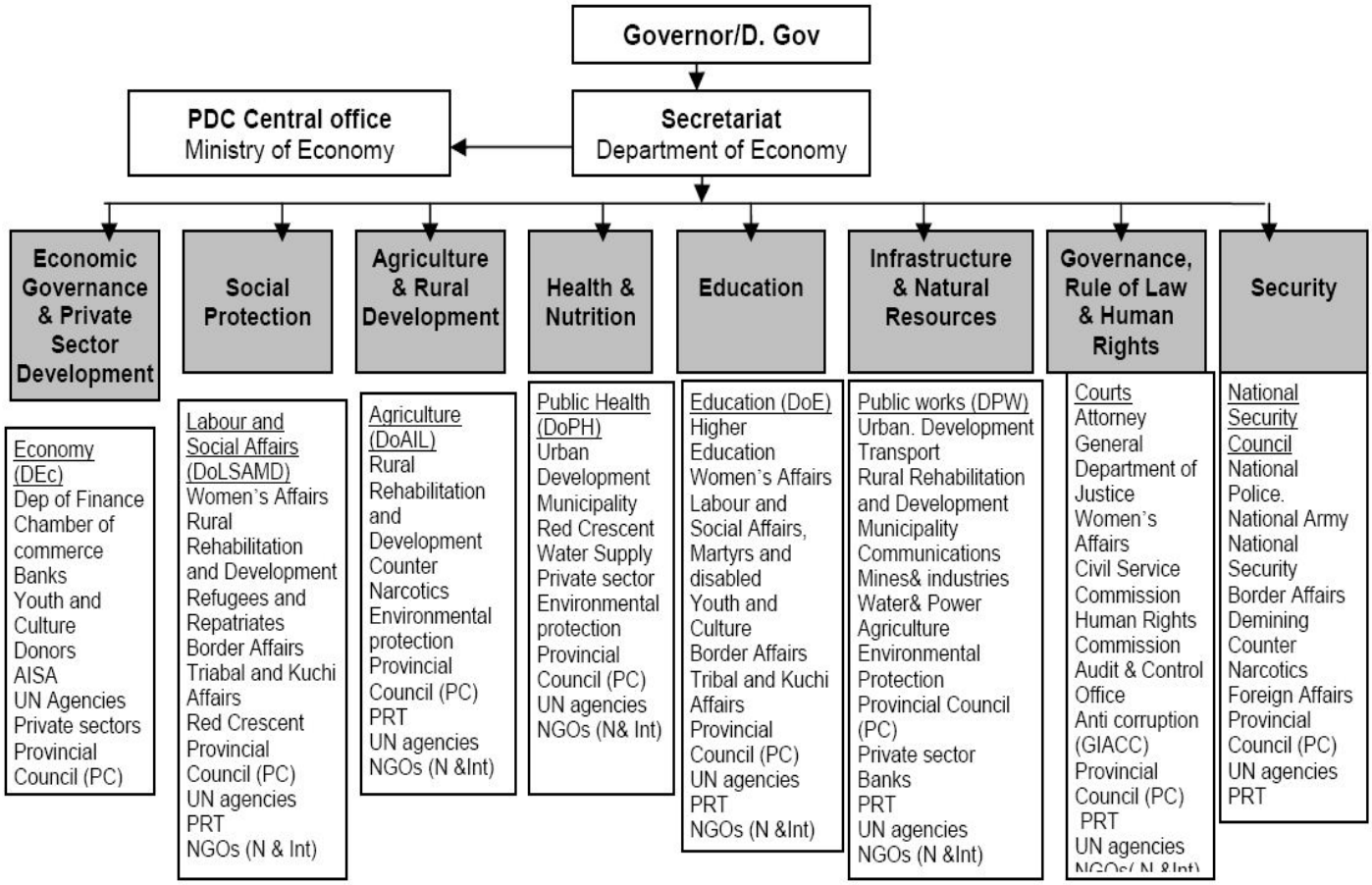
In total the government employs 11094 people in Nangarhar province. 75% of these are employees and 25% are contract workers. Around three quarters (71%) of government workers are men and just under a third (29%) are women.{Source: CSO Afghanistan Statistical Yearbook 2006}

Each province has a Provincial Development Committee (PDC) which is responsible for overseeing the progress made on implementation of the Provincial Development Plan, and which will lead the provincial development planning process in the future.

The PDC involves all government line departments and other key stakeholder groups involved in development activities in the province. It also has a number of working groups devoted to different sectors, each of which should be chaired by the director of the core responsible line department.

The structure of the PDC and its associated working groups approved by the Ministry of Economy for use in all provinces is shown in the diagram below:

Provincial Development Committee Structure endorsed by Ministry of Economy



Nangarhar also has a number of other bodies which play an active role in development planning at the local level. There are 605 Community Development Councils in the province which are active in development planning at the community and village level. There are none recorded in Hisarak District.

Households and Family Structure

In Nangarhar province as a whole there is a total population of 1,342,514 comprising some 182,425 households which on average have 8 members. If the ratio is reasonably uniform throughout the province one would expect there to be about 3,560 households in Hisarak district.

The UNCHR estimate that 2,145of these households are female led[1] which seems a very high figure even considering the number of males who may have been killed in conflict. Some households have no adult member and these are obviously at high risk and high need and should be identified.

The number of households in Hesarak village is not known but is likely to be in the area of 1,500 since approximately 50% of the population of the Hisarak district reside in the Hesarak central area.

It is essential to ascertain basic details on :-

Head of household and whether head of household has deceased – number of members of household

Children and their ages

Details of childbirth and possible complications

Diet and adequacy of nutrition

Illnesses and general state of health

Other individuals may not fall into the family structure such as :-

Displaced persons (IDP) – estimated by UNHCR

Orphans – numbers unknown

Nomadic (Kuchi) – not usually in Hisarak district

Refugees and Asylum seekers – estimated by UNHCR

Returnees – estimated by UNHCR

[1] UNHCR Sub Office Jalalabad District Profile Hisarak 2/7/2002

The UNHCR estimate of expected migration was that in 2002 approximately 200 IDP families (Internally Displaced Persons) would enter the Hisarak district who had come from other areas of Afghanistan and about 1000 returnee families would re-enter the district from abroad (mainly Pakistan).

These returnees in general were faced with hardship on return and 65% of their houses had been destroyed during their absence.

> *'Most of the houses were destroyed during the USSR occupation. Due to the poor economic condition of the returnees they cannot reconstruct their houses and have found shelter in damaged houses, tents or with relatives'*.

This estimate needs to be updated and confirmed. It must also be borne in mind that displacement and returnee status is a constantly changing factor with some families moving back and forth several times.

Occupations

Most adults are employed in agriculture which is mainly cultivation of crops such as wheat, maize (corn) and rice in the areas adjacent to the rivers. The area was in the past one of the most productive areas for opium poppy but this was mainly eradicated post 2001 at the instigation of the USA. The UNDCP recorded 76 poppy-growing villages in Hisarak in 2000 (Source: Afghanistan Opium Poppy Survey 2002 Pre-assessment, UNDCP, February 2002).

Family plots of land are small having been subdivided as a result of inheritance by subsequent generations. The nature of the farming renders tractor use and mechanical harvesting difficult and hence Oxen are used for ploughing.

Animal husbandry is limited to fowl, goats, sheep, cattle and some donkeys.

Industrial crops such as cotton and sugar are produced in Nangarhar province but not within Hisarak district. The same applies to Honey, Olives and tobacco.

The UNHCR state that the district Shura have asked for assistance with trades and income generating projects - some inhabitants of the district are trained in trades such as carpet weaving and tailoring, but are unable to obtain raw materials. Jewellery and artisan trades are not a feature of Hisarak.

Numerous NGOs operate within Afghanistan but at the time of the 'Nangarhar Provincial Profile' (?2008) none were operating within Hizarak district.

Transport and Communications

Hisarak has a relatively good communication infrastructure with only 5.3% of areas not being accessible by road as opposed to the Provincial average of 12.1%

Road Types

District	Cars all season	Cars some seasons	No roads	Not Reported
Hesarak	43.2%	51.6%	5.3%	.0%
Total	54.0%	33.5%	12.1%	.4%

Residents wishing to travel into Hesarak village for access to services would need to travel by car or might walk – distances between villages are in the main walkable. Camels have been used for transport in the past. There is no bus service or public transport. There are some private hire vehicles and multiuse taxis which can be shared by several people travelling in the same direction.

There are patchy mobile telephone services but no land lines.

Some wireless internet connections are available in Hesarak village.

Media – Radio and Television reception is possible throughout the district.

There is no local newspaper coverage.

These issues have significance when one considers how to propagate a health message or advertise and encourage people to attend services or centres. Word of mouth is very important at present. In the future perhaps radio or TV or some distribution of leaflets will become possible.

Internet education programmes and on-line two way communication such as via skype or webcam tuition will not currently be possible due to erratic and slow service. CD or hard drive based pre-recorded education programmes will need to be substituted for live sessions.

Basic services

Water

According to DACAAR (March 2002), there are 115 shallow wells in the district, and a further 82 are required. The district shura reported that most springs and karezes (irrigation water channels) dry out during the summer season. A small number of shallow wells reportedly dry up as well. In some villages, people use local water reservoirs for their daily water consumption.

UNHCR reports that - Flooding has destroyed approximately 20% of previously arable land. In the summer, lack of water is reportedly a serious problem. The district shura reported that construction of water reservoirs in Abzangani and Ghuagiza is required.

Electricity

Across Nangarhar province**,** on average 19% of households have access to electricity with the majority of these relying on public electricity. Access to electricity is much greater in the urban area where 83% of households have access to electricity, however this figure falls to just 9% in rural areas, and only one third of these (3%) have access to public electricity.

In Hisarak generators are used by many families and some homes near running water are using hydro electric power. Solar power has potential for expansion within the district.

The use of solar power will be an important matter for a centre and provide a low cost power source.

Sanitation

There is no drainage system and houses are not equipped with toilets. In Hisarak, self made sanitation is employed or individuals use Dearan/Sahrah (see below).

In Nangarhar Province around one third (33%) of households in urban areas and only 2% of rural households have access to safe toilet facilities. The following table shows the kinds of toilet facilities used by households in the province:

Toilet facilities used by households						
	None / bush open field /	***Dearan / Sahrah*** (area in compound but not pit)	**Open pit**	**Traditional covered latrine**	**Improved latrine**	**Flush latrine**
%	7	30	4	53	5	1
Source: NRVA 2005						

Sanitary pits are not in use at present and this would appear to be a valuable adjunct to the health services provided. Teaching groups of villagers how to construct a septic pit is relatively easy and would have an important part to play in halting the spread of intestinal disease and oro-faecal spread of infection.

Health and access to Health and Welfare Services

The UNHCR reports that in 2001 there was one Basic Health Centre supported by the Swedish Committee for Afghanistan and WHO. According to the district shura, many patients are required to travel more than 30 km to reach the clinic. No transportation facilities are available. The clinic charges 40% of the cost of the medicine and a 1000 AFG fee. According to the doctor, TB and seasonal diseases are prevalent. Nutrition is reportedly poor.

In May 2001, WHO reported that there was one male doctor, 2 male nurses, 1 pharmacist, 2 vaccinators and 70 traditional birth attendants present in the district (Source: Health Resources by District, Eastern Region of Afghanistan, WHO, May 2001).

Before 1998 33 midwives were operating in the area and afterwards the numbers fell drastically resulting in there being none at the present time.

Up to date accurate information on health services is essential.

Education

According to UNICEF - The district elders expressed a willingness to send their children to school, but cited a shortage of schools, buildings, teachers and materials as major problems. The district profiling team observed classes being held in the open air and in tents without furniture or plastic sheets for students to sit on.

Data on number of schools, teachers and students provided by UNICEF(July 2002). This is in need of updating. Information is nearly ten years old.

Areas of Concern

The following issues need to be addressed and investigated:-

Effects of warfare – Displaced persons, refugees and returnees.

As a consequence of conflict families and individuals are facing bereavements and general losses; economic difficulties and loss of shelter and safe housing. They also suffer emotionally and psychologically and mental health issues remain unaddressed.

Two groups are particularly at risk -

- Orphans and child led families
- Female led families

Both have lost the 'bread-winner' and the protection of a male adult member.

Health and Welfare

Many report high levels of maternal mortality and infant mortality although accurate figures are not available. Basic antenatal and perinatal care is often lacking.

Levels of many infections such as Tuberculosis and (in some areas) Leishmaniasis and Malaria as well as gastroenteritis are high but not well documented.

Health education and prevention is lacking. Education in the area of hygiene and healthy living is required.

Education

Education is basic and IT / computer skills such as are essential in modern society are not covered. There is a general lack of resources and teaching staff.

Health Needs.

Why do the health needs of the population of Hisarak demand our attention?

Mortality and Morbidity in Afghanistan as a whole is at an unacceptably high level and rural areas have even more serious needs than the more advanced urban populations. The following National statistics illustrate this very clearly.

Life Expectancy:-

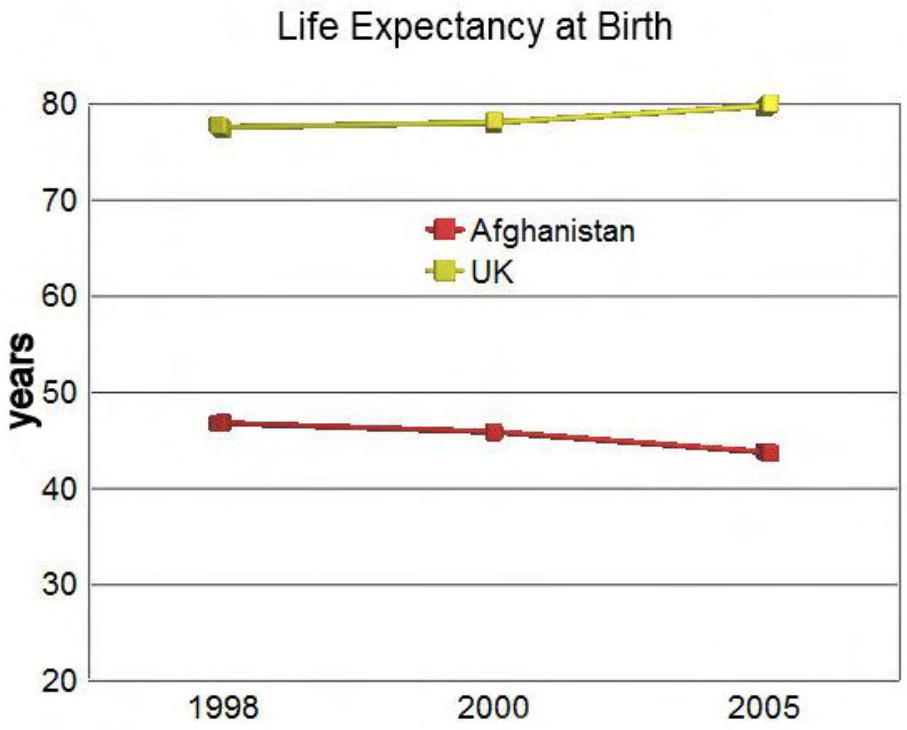
At the time of birth an Afghan baby can expect to live just under 44 years in comparison to a baby born in the United kingdom who can expect to live to nearly 83 years of age – almost twice the lifespan.

The table below shows data extracted from an analysis of 194 countries with a world average life expectancy at birth of 67.2 years ranging from the highest life expectancy in Japan (82.6) to the lowest in Swaziland (39.6). Afghanistan ranked near the bottom at 188 with a life expectancy 35% below the world average.

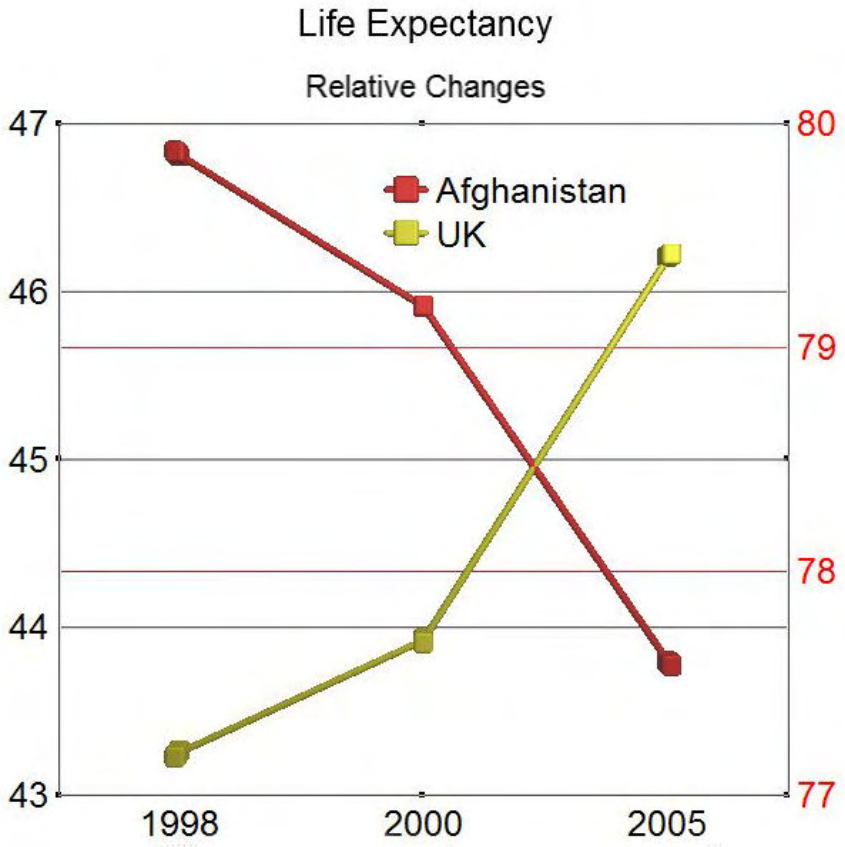
Rating	Country (State/territory)	Life expectancy at birth (years) Overall	Life expectancy at birth (years) Male	Life expectancy at birth (years) Female
188	Afghanistan (35% below world average)	43.8	43.9 (34% below world average)	43.8 (37% below world average)
20	United Kingdom	79.4	77.2	81.6
Highest	Japan	82.6	78.0	86.1
Average	World Avg.	67.2	65.0	69.5
Lowest (194)	Swaziland (40% below world average)	39.6	39.8	39.4

Data from U.S. Census Bureau's International Data Base. ; List by the United Nations (2005-2010) ; and United Nations World Population Prospects: 2006 revision – Table A.17 for 2005-2010

Of additional concern is the fact that, whilst the data for Afghanistan is not very accurate, it does appear that matters have become worse during the above period and that the life expectancy has fallen over recent years at a time when life expectancies in the developed world are increasing. A recent (2012) report by unicef and the Afghan ministry of Public health indicates that some improvement may have occurred in infant survival but this has yet to be verified.



If the relative changes in Afghan rates are compared with rates in the United States this becomes more obvious and concerning.



Female Life Expectancy

It is important to note that the rates show a lowered life expectancy for women. On a worldwide basis, women on average live about four years longer than men and in the UK there is a four and a half year gap, but in Afghanistan women have a slightly lower life expectancy. This is likely to be linked with maternal mortality and high rates of childbirth.

Life expectancy	Male	Female
Afghanistan	43.9 years	43.8 years
United Kingdom	77.2	81.6

In the United Kingdom women on average give birth to less than two children. The total fertility rate varies from year to year at about 1.9 births per woman. This is just below the 'replacement rate' of 2.1 births which are required to maintain a steady population size.

In contrast, in Afghanistan the rate is 6.3 births per woman, more than three times higher than in developed countries but the population growth is limited by the very high infant mortality rate.

Country (2008 data)[2]	Adolescent fertility rate[3]	Total fertility rate[4]
Afghanistan	109	6.3
UK	19	1.9

At the same time, more of these births are to very young mothers and the teenage fertility rate is 109 per thousand (some estimates place it higher) - which would mean that over ten percent of teenagers aged 15-19 are pregnant.

This compares with 39.1 births per thousand teenagers in the USA which is the highest rate for a developed country or 19 births per thousand teenagers in the UK – which has the highest rate in Europe, and extremely low levels in Japan.

The reasons behind teenage pregnancy rates in general vary depending on cultural norms, family structure, media influences and poverty.

In Afghanistan the extremely high rate of early births is culturally due to the early age of marriage but nevertheless these girls will be subject to medical issues of concern such as possible dietary deficiencies and lack of antenatal care. Maternal mortality is likely to be high in these young girls but reliable data is unavailable on this point.

[2] Adolescent fertility rate and total fertility rate United Nations, Department of Economic and Social Affairs, Population Division (2009), *World Population Prospects: The 2008 Revision. CD-ROM Edition*; supplemented by official national statistics published in United Nations *Demographic Yearbook 2008,* available from the United Nations Statistics Division website, http://unstats.un.org/unsd/demographic/products/dyb/default.htm

[3] Adolescent fertility rate is the number of births per 1000 women ages 15-19.

[4] The term total fertility rate is used to describe the total number of children the average women in a population is likely to have based on current birth rates throughout her life. The term 'fertility rate' is the number of live births occurring in a year per 1000 women of child-bearing age (usually 15-44)

Maternal Mortality:-

Country (2008 data)[5]	Estimated maternal mortality ratio[6] [7]
Afghanistan	1400[8]
UK	12

The rates of maternal mortality quoted above are estimated by WHO (see footnote) and are extremely high at about 1,400 maternal deaths per 100,000 live births ie 1.4%. This could well be an underestimate and rates of up to 1,800 have also been quoted throughout the 1990s and 2000. Regional variance also occurs. In some areas of Afghanistan this figure is even higher (up to 2,600).

These rates compare with the UK rates of about 12 per 100,000 or 0.012%.

In practical terms, the risk per woman is magnified by the high birth rate – if a woman has a 1.4% chance of dying in childbirth each time she gives birth; she will on average do this 6.3 times in her childbearing years and thus her overall risk of dying in childbirth is 8.8%.

Risk of dying in childbirth:-

Risk per pregnancy 1.4%
Average number of pregnancies 6.3

Overall risk per fertile woman – 8.8%
i.e. more than one out of every 9 women could die in childbirth

[5] Adolescent fertility rate and total fertility rate United Nations, Department of Economic and Social Affairs, Population Division (2009), *World Population Prospects: The 2008 Revision. CD-ROM Edition*; supplemented by official national statistics published in United Nations *Demographic Yearbook 2008,* available from the United Nations Statistics Division website, http://unstats..un.org/unsd/demographic/products/dyb/default.htm

[6] Maternal Mortality Ratio is the ratio of the number of maternal deaths per 100,000 live births.

[7] **Estimated maternal mortality ratio** Estimates developed by the World Health Organization http://apps.who.int/ghodata/ (accessed December 2010).

[8] UN Estimate:- For countries lacking complete vital registration or other acceptable national estimates of maternal mortality, the estimates are developed using a model. For each country, the regression model was used to predict the proportion maternal among deaths of women of reproductive age (PMDF), and the prediction was then applied to the WHO estimated envelope of HIV-adjusted deaths of women of reproductive age in 2000 to estimate maternal deaths. The MMR was then obtained by dividing the number of maternal deaths by an estimate of the number of births in 2000.

Infant and Child Mortality

The infant (deaths in first year) and child (under fives) mortality rates in Afghanistan as per the WHO tables[9], are the highest in the world and exceed the high levels in Chad and the Congo by over 20 deaths per thousand.

Country	Infant mortality rate[10]	Under 5 mortality rate
Afghanistan	147	220
United Kingdom	5	6

The reasons for this are several. Health issues and infections are compounded by poverty and deprivation consequent on warfare and loss of family income. Issues prevalent in the Hisarak area need to be assessed.

The tables below are compiled from WHO data but are incomplete and probably inaccurate. Many issues recorded by WHO in other countries have not been recorded in Afghanistan. The data can only be regarded as a pointer to areas for further exploration.

Causes of death among children aged <5 years (%) (2008)

Birth asphyxia	5.2
Congenital abnormalities	1.9
Diarrhoea	28.9
Injuries	3.9
Measles	0.6
Neonatal sepsis	4.2
Pneumonia	26
Prematurity	4.6

[9] World Health Organization http://apps.who.int/ghodata/ (updated December 2010).
[10] Infant mortality rate (probability of dying between birth and age 1 per 1000 live births)

Illness recorded in Children aged <5 years

Stunted for age (%)	59.3	2004
Underweight for age (%)	32.9	2004
Fever treated with antimalarial (%)	7.9	2008

The Prevalence of tuberculosis (per 100 000 population) is high at about 400 but the proportion of childhood cases is not recorded in WHO data.

Sadly most of the factors listed above would have been preventable both with better antenatal care, with better perinatal hygiene and with simple health education measures. Basic intervention could result in a good return in terms of improved health.

Geriatric Needs

The health needs of the elderly are not documented in current UN or WHO data sets. Due to the low life-expectancy fewer individuals reach a late age but harsh living conditions and socio/cultural factors contribute to the lack of provision for the elderly.

Male Health

Life expectancy has been discussed and no doubt the conditions of warfare and conflict have impacted on male mortality.

Males may be reluctant to seek advice or help with personal or medical matters and there are areas of unmet needs. Health education will make an important contribution to male health as well as educating heads of households with respect to the health needs of their families.

Mental Health

In the face of serious physical health issues, mental health can be ignored or minimised. It is important that issues such as depression and anxiety be confronted and that the symptoms of post traumatic stress be understood.

The high number of families touched by warfare and conflict; the bereaved and the orphaned all require emotional and psychological assistance.

A general support structure with mental health education can go a long way to achieving significant improvements in mental health.

In 2005 around half of all households in the province report having been negatively affected by some unexpected event in the last year, which was beyond their control (48%). Rural households were much more vulnerable to such shocks, with 55% of households affected, as opposed to urban households with only 32%. People living

in urban areas were most vulnerable to shocks related to natural disasters and insecurity, whereas those in rural areas were most at risk from drinking water problems and natural disasters, Of those households affected, around two thirds reported that they had not recovered at all from shocks experienced in the last 12 months (63%), and more than one third said they had recovered only partially (35%). [11]

This inability to recover from adverse conditions indicates a need to intervene and set up a service aimed at the treatment of traumatic stress.

Substance Abuse and Addiction

This is a major problem and treatment and rehabilitation is the subject of one of our projects and of a separate paper.

Substance abuse is always a problem in war torn areas. Traditionally both fighting men under pressure and, to a lesser extent, those oppressed by warfare have sought temporary relief from fear, stress and fatigue though use of drugs and alcohol.

Afghanistan poses its own specific problems due to local production of drugs and the extent of families and children involved.

[11] UNAMA district profile