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 Kandahar 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

Kandahar (Pashto: كنـدهار *Kandahār*, Persian: قنـدهار *Qandahār*) province which is located in the south of the country at about 1,005 m (3,297 feet) above sea level contains the city of the same name which is is the second largest city in Afghanistan. The Arghandab River runs along the west of the city

Kandahar province is located in the southern region of the country and has borders with Zabul in the East, Uruzgan in the North, Helmand in the West and an international border with the Balochistan Province of Pakistan in the South. The province covers an area of 47676 km2. More than four-fifths of the area is made up of flat land (84.5%) while nearly a tenth of the province is mountainous or semi mountainous terrain (7.6%)[1]

The flat land of Kandahar province consists of farmland which has been traditionally well irrigated and the area is known for its crops of grapes, melons, and pomegranates and also grows tomatoes.

The province has a population of 990,000 and it is estimated that about 500,000 live in the capital city. Around 68% of the population of Kandahar lives in rural districts while 32% live in urban areas.

The population is ethnically mixed but mainly Pashtun Pashtu is spoken by more than 98% of population and in more than 98% of villages. Dari is spoken in six villages by 4000 people and Balochi is spoken by 8000 people in two villages. 19000 people in nine villages speak some other unspecified language. Kandahar province also has a population of Kuchis or nomads whose numbers vary in different seasons. In winter 79,949 individuals, or 3.3% of the overall Kuchi population, stay in Kandahar.

[1] **UNDSS Provincial Profile, provided by UNAMA**

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There are approximately 14,445 households in the province, and households on average have 7 members.

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}.

Many demographic details with respect to Kandahar are not recorded and hence it will be essential to gather some baseline information in order to facilitate the planning of restorative services. There are large numbers of the population who are

internally displaced refugees who may have travelled to other provinces and then on to refugee camps in Kabul or elsewhere. The area has been unstable and disrupted by ongoing fighting. Many of the farmers particularly have found themselves caught in 'the crossfire' of the conflict and have had to leave the area, thus having a negative effect on the development of rural areas.

Institutional framework

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

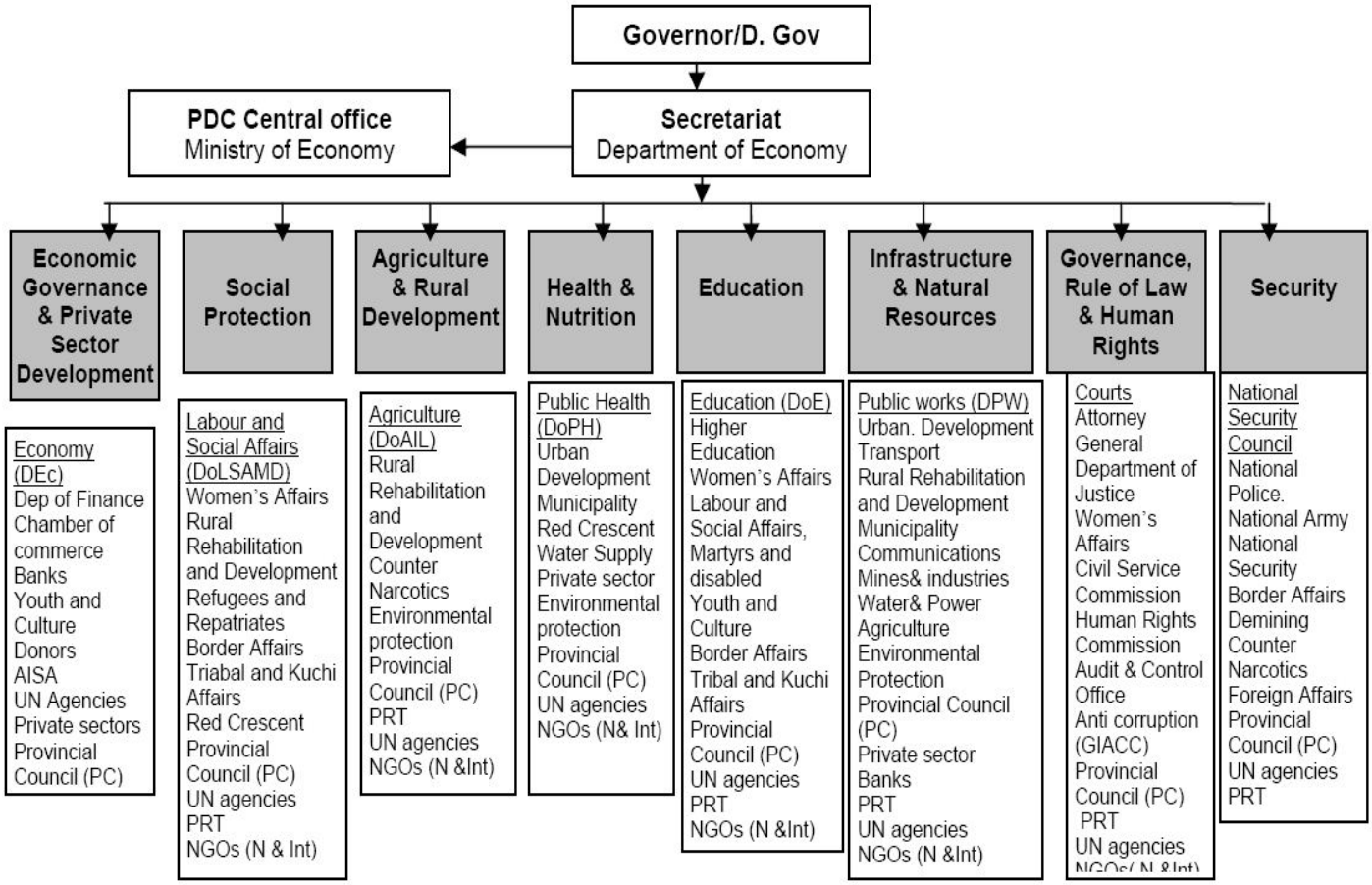
The Provincial Development Committee in Kandahar province was formed in mid 2005.

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



Kandahar also has a number of other bodies which play an active role in development planning at the local level. There are District Development Assemblies active in 17 districts in the province, involving 498 men and 231 women members. Each DDA has its own District Development Plan. There are also 496 Community Development Councils in the province which are active in development planning at the community and village level.

Households and Family Structure

In Kandahar province as a whole there is a total population of about 1 million (estimates vary from 900,000 to 1,300,000) comprising some 14,445 households in the province, and households on average have 7 members.

The UNCHR estimate that about 15% of these households are female led[2] which seems a 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.

In order to adequately plan health and support services 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) –

Refugees and Asylum seekers – estimated by UNHCR

[2] UNHCR District Profile 2/7/2002

Returnees – estimated by UNHCR 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.

According to the UNHCR - In 2001 there were approximately 1.2 million internally displaced Afghans throughout the country. The majority of these IDPs were to return spontaneously to their places of origin over the course of several years. Some 99,508 families (493,556 individuals) were assisted by UNHCR from 2002 until 2009 on the basis of a Memorandum of Understanding signed between the Government of Afghanistan, UNAMA and UNHCR which gave UNHCR a lead support role in relation to IDPs. The majority returned to the north (35%), west (32%) and central (21%) regions.

Many internally displaced refugees from the Kandahar area are still residing in camps in other parts of the country – particularly in Kabul where their conditions are extremely poor. These people will need assistance if and when they return to Kandahar.

Occupations

Most adults are employed in agriculture which is mainly cultivation of crops such as pomegranate, grapes, tomatoes. The area was in the past one of the productive areas for opium poppy but this was mainly eradicated post 2001 at the instigation of the USA. (Source: Afghanistan Opium Poppy Survey 2002 Pre-assessment, UNDCP, February 2002).

Sources of income reported by households			
Source of income	**Rural (%)**	**Urban (%)**	**Total (%)**
Agriculture	38	8	28
Livestock	8	1	8
Opium	6	1	4
Trade and Services	23	43	29
Manufacture	3	2	2
Non-Farm Labour	37	27	34
Remittances	7	0	5
Other	5	21	10

Source: NRVA 2005

The most important field crops grown in Kandahar province include wheat, potatoes, melon and watermelon and maize as well as opium. The most common crops grown in garden plots include grapes (54%) and fruit and nut trees (34%). Wheat (4%) and vegetables (3%) are also sometimes grown in garden plots in the province.

Transport and Communications

Kandahar has a relatively good communication infrastructure with 76.8% of roads in the province able to take car traffic in all seasons, and 19.1% able to take car traffic in some seasons. However, in a very small area of the province (3.3%) there are no roads at all,

There are good mobile telephone services in the city and close to main roads.

Some wireless internet connections are available.

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

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.

Basic services

Water

The provision of basic infrastructure such as water and sanitation, energy, transport and communications is one of the key elements necessary to provide the building blocks for private sector expansion, equitable economic growth, increased employment and accelerated agricultural productivity. In Kandahar province, on average only 64% of households use safe drinking water. This rises to 99% in the urban area, and falls to 50% in rural areas.

More than four fifths (87%) of households have direct access to their main source of drinking water within their community, however one in ten households has to travel for up to an hour to access drinking water (10%)

Electricity

Across Kandahar province**,** on average 27% 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 85% of households have access to electricity, however this figure falls to just 2% in rural areas, and only half of these (1%) have access to public electricity.

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

On average only 22% of households have access to safe toilet facilities. The situation is better in the urban area where 57% of households have safe toilets, but this is true for only 7% of rural households. 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**
%	6	20	3	49	19	3
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 a basic infrastructure of health services exists in Kandahar province. In 2005 there were 20 health centers and 8 hospitals with a total of 375 beds. There were also 140 doctors and 288 nurses employed by the Ministry of Health working in the province, which represented nearly twice as many doctors (up from 77) and 50% more nurses (up from 188) since 2003.

Up to date accurate information on health services is essential.

Services are not comprehensive and are in scant supply and irregularly distributed.

The majority of communities do not have a health worker permanently present in their community.

Thirty nine percent of men's shura and 59% of women's shura reported that there was no community health worker present, and both groups most commonly said that a basic health centre or clinic without beds is their nearest health facility. Only 3.5% of the population has a health center and 4.2% has a dispensary within their village. Around half the population seeking medical attention must travel more than ten kilometers (55% for health centers and 51% for dispensaries). [3]

[3] UNAMA district profile

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.

The overall literacy rate in Kandahar province is 16%, however, while more than a quarter of men are literate (26%), this is true for just one twentieth of women (5%).

The disproportionate levels of education between the genders is replicated at all levels.

Primary and Secondary Education

	Schools		Students		Teachers	
	boys	**girls**	**boys**	**girls**	**male**	**female**
Primary	192	2	113102	25862	-	-
Secondary	70	7	10877	501	-	-
Total	262	9	123979	26363	2294	184
	271		150342		2478	

Source: CSO Afghanistan Statistical Yearbook 2006

Kandahar city has a university with faculties of medicine, teaching, agriculture and engineering. Facilities and resources are poor.

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 Kandahar 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:-

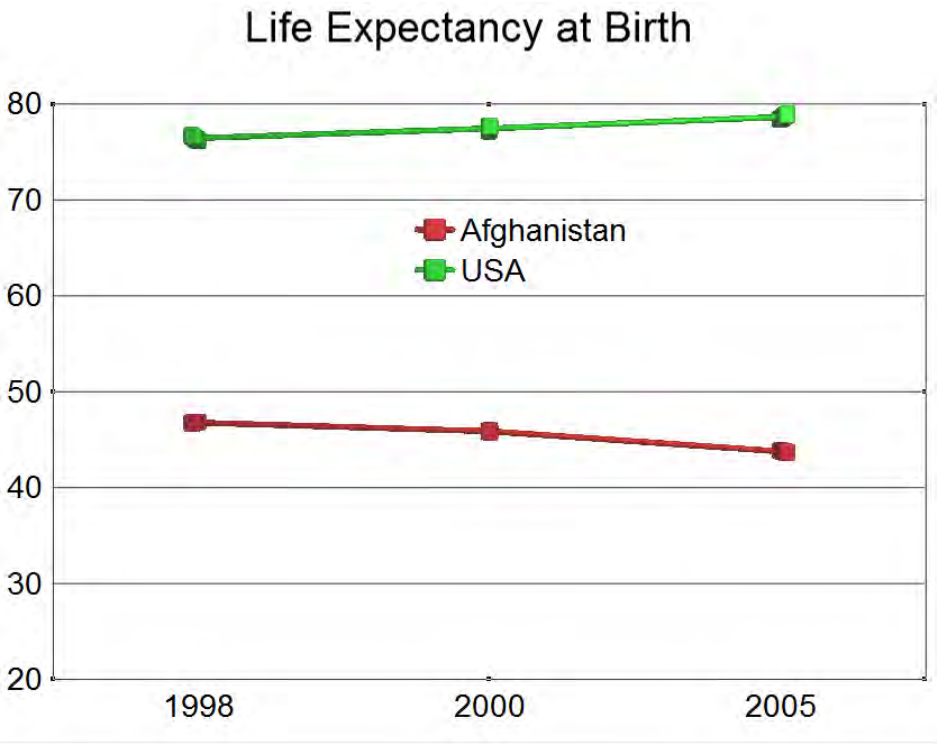
At the time of birth an Afghan baby can expect to live just under 44 years in comparison to a baby born in the United States who can expect to live to 78 years of age – almost twice the lifespan.

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.

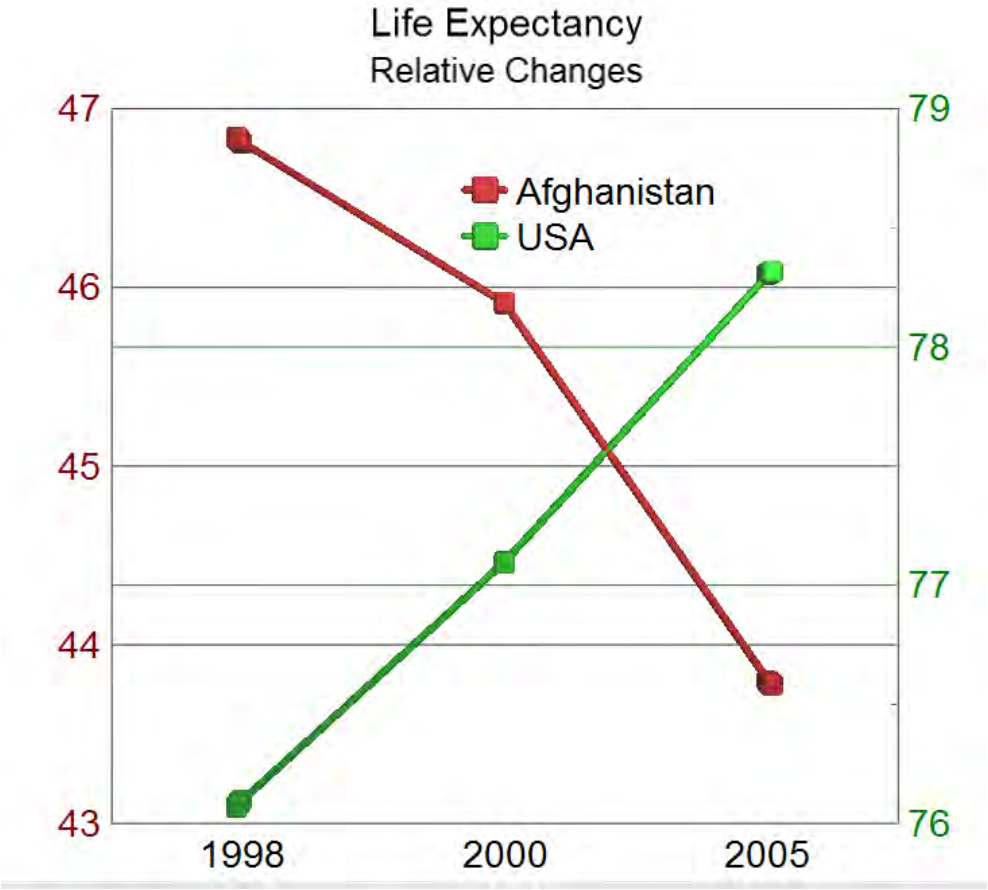
Rating	Country (State/territory)	Life expectancy at birth (years) Overall	Life expectancy at birth (years) Male	Life expectancy at birth (years) Female
188	Afghanistan (35% below world average)	43.8	43.9 (34% below world average)	43.8 (37% below world average)
36	United States	78.3	75.6	80.8
Highest	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 are becoming worse and that the life expectancy has fallen over recent years at a time when life expectancies in the developed world are increasing.



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 USA there is a five 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 States	75.6	80.8

In the United States women on average give birth to less than two children. The total fertility rate varies from year to year from about 1.7 to 2.0 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)[4]	Adolescent fertility rate[5]	Total fertility rate[6]
Afghanistan	109	6.3
USA	41	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.

[4] 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

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

[6] 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)[7]	Estimated maternal mortality ratio[8] [9]
Afghanistan	1400[10]
USA	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 USA 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

[7] 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

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

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

[10] 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[11], 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[12]	Under 5 mortality rate
Afghanistan	147	220
United States	6	7

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 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

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

Illness recorded in Children aged <5 years

	59.3	2004
Stunted for age (%)		
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%). [13]

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.

[13] UNAMA district profile