Report to Women's Commission for Refugee Women and Children International Rescue Committee

Status of Afghan Women and Children Refugees
Cynthia Lawrence Haq M.D., March 1989

Imagine you are a 36 year old Afghan woman living in a refugee camp just outside Peshawar, Pakistan. Nine years ago, you and your family fled your home in rural Afghanistan fearing for your lives. A brutal civil war was raging, your brother had been killed, your husband was imprisoned, bombings around your village were commonplace, and the countryside was littered with land mines. You gathered a few possessions which could be carried and traveled with your four young children, your husband's parents, your brother and sister-in-law and their five children over the cold and snowy Afghan mountains by foot for five days until you reached the relative safety of a refugee camp in Pakistan. Two members of your family died in route; your brother in a land mine accident, and your three year old daughter from pneumonia.

After one year in the camp you were joined by your husband. Since then you have had three more children. Your life consists of caring for your seven children, your husband's parents and supporting your widowed sister-in-law and her children. You live in a small mud hut which you and your family built after arrival. Food and water are scarce, but available through rationings. Since your husband was fortunate to find a job building roads outside Peshawar, your family has some money to buy other foods. You are able to obtain medical care at a health center located on the periphery of the camp. Your three sons attend school in the camp in the mornings. Your daughters stay home with you as the mullahs say that schooling for girls and women is contrary to the teachings of Islam. Since you never attended school, you are unable to read or write. You are unable to leave the confines of your compound unless completely covered by veil.

You and your family are very unhappy here. You feel trapped with little freedom to move about, scarce necessities and an uncertain future. You have heard that your village was destroyed and the war continues. You have no idea when you will be able to return to your devastated homeland, or what rules the next political regime will enforce. You often feel helpless and hopeless.

This scenario comes from the true life story of an Afghan woman living in Nasir Bagh camp interviewed in February, 1989.

During the last week of February, 1989, by invitation of the Women's Commission on Refugee Women and Children of the International Rescue Committee, I visited Peshawar, Pakistan to investigate the status of Afghan women and children refugees, to identify needs and begin program planning for repatriation.
Discussions were held with the following groups and individuals:

Afghan women, men and children refugees of Nasir Bagh and Gondolf camps in the Northwest Frontier province of Pakistan

Drs. Momand, Turner and other physician and nursing staff of the Afghan Obstetric and Gynaecology Hospital, Peshawar

Principal Tajwar Kakar, teachers and students of the Lycee Malalai secondary school for Afghan refugee girls

Dr. Rachman Zumeni and physician and community health worker staff of Gondolf camp (Austrian relief committee)

Mr. Thomas Yates, Director; Mr. Steven Segal, Deputy Director;
Ms. Susan Yates and Ms. Charlotte Albers International Rescue Committee

Mr. Ted Albers, Executive Coordinator ACBAR (Agency Coordinating Body for Afghan Relief) Beverly Fleming, secretariat, and members of ACBAR Health Subcommittee

Dr.. Lillian Rachlin and Sheila Ludjens RN of the International Medical Corps

Ms. Margaret Segal, Education Coordinator, Development Center for Afghan Education

Theresa Molyneux, Mother-Child Centre Coordinator, Afifa Wardak and other teachers of the International Rescue Committee and Bernard van Leer Foundation

Margaret Sinclair, Program officer; Anitha Ronstrom, Master Trainer
UNHCR (United Nations High Commission for Refugees)

Kerry Connor, Ph.D. UNICEF

Jean Canby, R.N., Community Health Programmer Serve

Chief Minister Aftad Sherpao, Northwest Frontier Province, Pakistan

INTRODUCTION

Since 1979 more than seven million Afghans have had to abandon their homes to seek asylum from war. Over 70% of the refugee and internally displaced populations are women and children.

Early in 1989 the Women's Commission for Refugee Women and Children of the International Rescue Committee was formed to investigate and exclusively target the needs of refugee women and children throughout the world. In February I traveled to Peshawar, Pakistan, to investigate the status of Afghan women and children refugees and to identify areas of need. The purpose of this report is to briefly summarize the status of women and children refugees, identify problems, and to suggest strategies which might help currently, and during repatriation. I have relied heavily on the experience and knowledge of Nancy Dupree and the above mentioned individuals, and am thankful for their time and frankness with me. As a mother and family physician, I am familiar with maternal-child family and health issues. Being Pakistani, I am familiar with many of the cultural issues affecting Afghan women.

This report is not designed to provide a comprehensive overview of the Afghan refugee's situation and problems. For this the reader is referred to the First Consolidated Report from the office of the United Nations Co-ordinator for humanitarian and economic assistance programmes relating to Afghanistan by Sadruddin Aga Khan. Nor is it designed to comprehensively address problems of repatriation; for this the reader is referred to the first and second reports of the Citizen's Commission on Afghan Refugees available from the International Rescue Committee. Instead, this report will focus on problems specific to Afghan women and children refugees.

STATUS OF AFGHAN WOMEN AND CHILDREN REFUGEES

Cultural status

In order to fully understand the status and problems of Afghan women and children, it is important to keep in mind the traditional roles and responsibilities women have maintained, and how these have changed over time. Motherhood is the most sought after role for women, the family is the most important institution, and women are the core of families in Afghan society. The roles of women in urban and rural society differ, and have changed over time (1).

In pre-war Afghanistan rural women lived in kin-related segments of villages and were free to move about, usually wearing long scarves, but rarely completely veiled. They participated in light agricultural tasks, processing of grains, wool and vegetables, and some harvesting. They also cared for children and the home. Women rarely were schooled or participated directly in money making activities.

Urban women prior to 1959 were more strictly confined to domestic and reproductive activities and the confines of their homes. They rarely

ventured out without a male escort, or when completely veiled. Early in the 20th century a movement for more equitable women's rights began and developed into the passage of marriage laws, discouragement of the veil, and women's participation in development, education and medicine. Religious opposition feared that increased female mobility would lead to the breakdown of Islamic social order. Despite periodic setbacks, the 1964 constitution guaranteed women equal rights, and 1977 Civil Law provided women protection against forced marriages. The laws were not universally enforced, and the pattern of male domination continued in most areas. Following the coup by leadership of the People's Democratic of Afghanistan, promises for a new era providing absolute equality for women were made but few tangible benefits were seen. Women became more visible in public, and party members were able to join the university. Many members of Afghan society viewed the increased visibility of women in public with extreme distaste, and associated programs to educate women and girls as communistic undermining of the fabric of their society (1).

Women refugees have experienced the imposition of stricter behavioral codes. Because refugee camps are not closely kin related, as were most villages in Afghanistan, any movement of women outside their homes is viewed as risky, and generally allowed only with a relative male escort, veiled and under close supervision. Urban refugee women enjoy greater freedom, but are seen in public less often than prior to the war, and must keep their heads covered at all times in mixed company. Educational programs for women had been viewed with suspicion and associated with communism. Because of these constraints, educational and development programs directed towards women must be undertaken with caution, and after obtaining approval from male leaders in the camps. During recent years more women have been encouraged and allowed to take advantage of professional opportunities due to economic benefits.

Health Status of Women

It is estimated that there are over five million Afghan women and children refugees. Basic health indicators reflecting the health status of all Afghan refugee women and children are not available but a few surveys have been performed. From surveys of 10 camps in 1987, the current estimated fertility rate of 400 live births per 1000 women of childbearing age is the highest in the world. If this rate continues unchanged, Afghan women will average 13.6 live births during their childbearing years. During the time of the survey one out of four women of childbearing age was pregnant. Of these, 19% received prenatal care. Only 3.5% of women had received tetanus immunization. Less than 10% of women received professional birth assistance (trained traditional birth attendant, health worker or hospital delivery). Maternal mortality rates are unavailable, but in 1987 1.3 out of every 100 women reported a maternal death during childbirth among their relatives (2).

Given the high fertility rate of Afghan refugee women, many potential

problems result. Close spacing of pregnancies results in lower birth weights of infants, a greater tendency for maternal and child malnutrition and greater rates of maternal anemia and birth complications. Of women surveyed in 1987, over 60% favored the idea of child spacing, but only 3% employed child spacing methods. Further exploration of women's and men's attitudes toward child spacing could lead to the offering of child spacing programs that are acceptable and used by greater numbers.

Availability of basic health services for women in the camps is generally good, and over time trust has been established leading to greater utilization. Only one hospital devoted to the health needs of Afghan women exists in Peshawar, the Afghan Obstetric and Gynaecology Hospital. Established in 1984, the hospital serves women in prenatal care, delivery and gynaecological surgery. Since its establishment, patient volume has grown steadily, with over 10,000 out patient visits, 1000 deliveries, and 100 major surgeries in 1987. Despite the hospital's success in growth, funding cuts have threatened curtailments in services rendered.

The existence of a cadre of health professionals able to serve the health needs of Afghan women, upon their return to Afghanistan, is crucial to prevent dramatic increases in maternal-child morbidity and mortality. The need exists for further training of female health workers at all levels, continued surveillance of women's health status and efforts to immunize all women of childbearing age against tetanus.

Health Status of Children

In 1987, 22 out of 1000 infants born died in their first month of life, and 104 out of 1000 children died before their fifth birthday. This represents a significant reduction of infant and child mortality rates since 1979. High birth rates, coupled with lower infant and child mortality rates have led to extremely rapid population growth among the refugee population and a greater proportion of dependent children to adults.

Moderate to severe malnutrition was present in approximately 12% of children in the camps. Vaccination rates of children with BCG was 79%, measles 64%, and fully for DPT/Polio was 25% (1). Diarrhea, dehydration, measles, tuberculosis, respiratory infections, polio, trachoma, typhoid fever and neonatal tetanus are still common among the refugees.

Despite serious and persistent health problems, due to the efforts of Afghans, voluntary agencies and support from the Government of Pakistan, overall health status and access to health services of women and children refugees has been considerably improved over pre-war Afghanistan Coordination and continuation of health services currently available will become more difficult as refugees return to Afghanistan. Efforts to immunize as many children as possible prior to the move should be continued. The training of community health workers, who will probably be the main source of medical care available in rural areas, should be continued with this fact in mind.

Vulnerable Groups

Up to a million people have been killed in the ten years war in Afghanistan, more than 60% of the losses have been adult males. This has resulted in the creation of up to 700,000 widows and orphans. Additionally, due to the protracted war and heavy civilian casualties, there are thousands of handicapped men, women and children refugees. Because of a closely knit extended family system that has existed in Afghanistan for generations, the majority of needy individuals are expected to be cared for within their families. Because of the large numbers of dependent children, widows and handicapped, the extended family's ability to absorb and adequately care for all in need will likely be exceeded. Accurate estimates of the number of refugees with special needs and their location do not exist. Training of Afghans, who could identify needy individuals, and help in coordination of services after repatriation, could insure that these groups receive the special services they require.

Educational Status

Over 90% of Afghan women are illiterate, and 85% are from rural areas of Afghanistan. The use of child spacing methods and the health of children, is directly related to maternal educational status. Education of women is not contrary to the teachings of Islam. Due to the limited mobility of adult women in refugee camps, educational programs targeted at adult women have met with very limited success, but have been successful with some urban refugees. Most of the refugee camps contain schools for children, and efforts are underway to standardize curriculae. Young boys commonly attend grade school, and many have the opportunity to attend secondary schools. Young girls rarely attend grade school, and if they do the attrition rate as they reach higher grades is great. Some school programs for girls have been more successful when *mullahs* (religious teachers) have been employed as teachers. Only one secondary school for refugee girls exists in Peshawar, the Lycee Malalai school with just over 100 students. The formation and operation of secondary schools for young women has generated political controversy, resulting in temporary forced closures. Post secondary educational opportunities for men and women are limited, restricting professional development of this important sector of Afghan society. Despite the difficulties associated with development and delivery of appropriate school curriculae to children and young adults, the opportunity to receive education, for those interested and permitted is crucial. Teacher training in preparation for repatriation must occur throughout the school systems to insure program continuity. Interaction of professionals inside Afghanistan with refugees is currently limited. It is difficult to predict to what extent professionals within Afghanistan will be able to fulfill the needs of local and refugee populations following repatraition.

Recommendations

The brief summary above, emphasizes some of the current and anticipated problems for Afghan refugee women and children. Many of these problems are being addressed by the Afghans themselves,the Pakistan government, and voluntary agencies. Through incredible international efforts and cooperation, major catastrophes among the refugee population have been averted. Some of the specific needs of women and children refugees have not been addressed, either because of other pressing priorities, lack of resources, cultural constraints making work with women difficult, or non-recognition of the special needs of women. By addressing the special needs of women and children refugees, Afghan society can be strengthened and rehabilitated throughout. Below are recommendations for a few programs which are felt to be priorities, but are not inclusive of all needed programs, or ones that are already being addressed.

Women's Social Service Center

There is currently no mechanism that exists in the refugee population that allows women to interact, share ideas and develop their own programs. There are a number of educated and professional Afghan women living in Pakistan who plan to return to Afghanistan as soon as possible. By facilitating the interaction of women who can articulate their own problems, develop ideas for programs, and begin these to carry on following repatriation, women will be given a voice, and the opportunity to participate in development planning. To insure the support of male leaders it is important that this forum be constructed in a culturally sensitive way. Development of a **women's social service center** in Peshawar could serve as the central body for professional associations of teachers, health workers and women with other special interests. Due to economic, cultural and transportation constraints, external economic support of this group would be essential for its development.

Identifying Vulnerable Groups

The large numbers of **handicapped** individuals will require special programs to help with their achievement of rehabilitation and self sufficiency. Before effective programs can be developed and implemented, these individuals must first be identified, and their needs assessed. The first task of the Women's Social Service Center could be to begin planning and identification of these individuals. Training of Afghan community social workers who could identify vulnerable families, and refer them to the appropriate social service agencies is critical in coordinating services for these needy individuals.

Widows, particularly mothers with dependent children, form another large group with special needs. Identification of these women could also be achieved by Afghan community workers. The development of

mechanisms for these widows to achieve economic self sufficiency through agricultural, tailoring or handicraft programs will decrease their dependency and vulnerability, and could be identified by the widows and their community workers and coordinated through the women's social service center.

Teaching Programs

The importance of **educational opportunities for male and female children** of all ages cannot be overemphasized. Despite the limited acceptance of education for girls, efforts should continue to enhance female participation. Successful programs which have achieved cultural acceptability, by incorporating religious teachers into curricular development should be expanded.

The role of education as enhancing the *jihad* and individual's abilities to serve others should be stressed. Political leaders who favor education of all children should be encouraged to speak in its support. If ways of making education culturally acceptable can be found, the ability to reach women and children will be enhanced.

Women should be recruited for training as community health workers, teachers, traditional birth attendants and social workers. The training of male community health workers has been very successful in many camps, and in some areas , males are accepted readily when they are the only choice available for provision of health care. Through the training of women, the majority of Afghan women and children be reached optimally.

Health Needs

Efforts to **vaccinate all women and children** prior to repatriation should be increased, as provision of immunizations will become more difficult following dispersion of the population to rural areas. Health education should be provided as a priority in conjunction with curative care, and throughout the school curriculae.

Exploration of **attitudes towards child spacing** should be carried out. Provision of child spacing techniques and education should be provided to those who are interested.

Availability of **basic health services** to all in the camps should be continued with the knowledge that the number of refugees in the camps may grow in the upcoming months if fighting continues in Afgnanistan. Reduction in camp services should begin only after the refugees are clearly returning, and plans for mobilizing health teams to Afghanistan should begin now. The funding for successful programs, such as the Afghan OBS/ GYN Hospital in Peshawar, should not be curtailed.

Women's Representation

Afghan women refugees are for the most part, a silent and unseen

group. In order t[illegible]est understand their needs, and imple[illegible]nt their ideas they must be hea[illegible]. An effort should be made to obtain **women's representation at all levels** of refugee and repatriation program planning. Coordinators of women's and children's affairs should be appointed by the Pakistan and interim Afghan governments, and in voluntary agencies. A mechanism for communication among these women's representatives should be established for optimal coordination of efforts. Every effort should be made to allow Afghan women to speak for themselves.

References

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2 Krijgh, E. Health Status of Afghan Women and Children. An assessment of trends in 10 refugee camps between Hangu and Thal, Northwest Frontier Province, Pakistan. 1987