

Children and Women in Afghanistan: A Situation Analysis 2014

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برای اطفال متحد شوید

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During this process every attempt has been made to update the report following the release of new data and include important policy developments.

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Foreword

Promoting, protecting and fulfilling human rights, particularly children's rights is one of the most effective and sustainable ways of reducing poverty and ensuring equity. While Afghanistan has made commendable progress in some areas, other areas are lagging or are not being addressed sufficiently. The Situation Analysis of Children and Women in Afghanistan 2014 (SitAn) aims to take stock of Afghanistan's achievements in protecting and promoting children's rights and to better understand the degree to which laws, policies, mechanisms and practices reflect international child rights standards.

The report focuses on basic social services including health, nutrition, water, sanitation and hygiene, education, and child protection. In addition to an assessment of basic services, there have been detailed analyses of a wide range of contextual dimensions (political, legal, social, economic, cultural) that help to better understand their influence on growth and development of Afghan children and women.

Through the process of gathering available evidence on the situation of children and women in Afghanistan, UNICEF aims to fill the gap in the analysis and provide recommendations in formulating a balanced sustainable development agenda for the country that puts the rights of children and women up front. This analysis also informs UNICEF's new Country Programme for 2015-2019 in Afghanistan.

The SitAn uses human rights and equity as frameworks to analyze the current situation of the fulfillment of rights of children and women in the country and articulates the progress made towards achieving the rights related to the Millennium Development Goal (MDG) targets of maternal health, under-five mortality, and access to primary education alongside rights related to protection from violence, abuse, neglect and exploitation.

The guiding references for this SitAn are the MDGs, the Convention on the Rights of the Child (CRC); the Afghanistan CRC Concluding Observations (and shadow paper by Civil Society); International Human Rights conventions, including the Convention on the Elimination of All forms of Discrimination Against Women (CEDAW); the Convention on the Rights of Persons with Disabilities (CRPD); and the United Nations Security Council Resolution 1325, which provides guidance on the protection of women in conflict situations.

Present in Afghanistan for over 60 years, UNICEF continues our unwavering commitment to advance the rights of Afghan children and women.

Akhil Iyer
Representative
UNICEF Afghanistan Country Office

Acronyms

AARR	Average Annual Rate of Reduction
AGE	Anti-Government Entities
AIHRC	Afghanistan Independent Human Rights Commission
ALCs	Accelerated Learning Centres
AMS	Afghanistan Mortality Survey
ANDS	Afghanistan National Development Strategy
ANSF	Afghan National Security Forces
ARCS	Afghan Red Crescent Society
AREU	Afghanistan Research and Evaluation Unit
BCG	Bacillus Calmette–Guérin vaccine for tuberculosis
BPHS	Basic Package of Health Services
CBE	Community-based Education
CBS	Community-based Schools
CEDAW	Convention on the Elimination of All Forms of Discrimination Against Women
CDC	Community Development Council
CDI	Child Deprivation Index
CFS	Child-friendly School
CPAN	Child Protection Action Network
CRC	Convention on the Rights of the Child
DACAAR	Danish Committee for Aid to Afghan Refugees
DPT3	Diphtheria, Pertussis and Tetanus (3 doses)
EFA	Education for All
EPHS	Essential Package of Hospital Services
EMIS	Education Management Information System
ERWs	Explosive Remnants of War
EVAW	Elimination of Violence Against Women
GER	Gross Enrolment Ratios
GDP	Gross Domestic Product
GPE	Global Partnership for Education
GoIRA	Government of the Islamic Republic of Afghanistan
HMIS	Health Management Information System
IFRC	International Federation of the Red Cross and Red Crescent Societies
IDPs	Internally Displaced Persons
IEDs	Improvised Explosive Devices



ILO	International Labour Organization
MDGs	Millennium Development Goals
MICS	Multiple Indicator Cluster Survey
MMR	Maternal Mortality Ratio
MNCH	Maternal, Newborn and Child Health
MoE	Ministry of Education
MoJ	Ministry of Justice
MoLSAMD	Ministry of Labour, Social Affairs, Martyrs and the Disabled
MoPH	Ministry of Public Health
MoRR	Ministry of Refugees and Repatriation
MRM CAAC	Monitoring and Reporting Mechanism on Children and Armed Conflict
MRRD	Ministry of Rural Rehabilitation and Development
NEPI	National Expanded Programme on Immunization
NESP	National Education Strategic Plan
NGOs	Non-Governmental Organizations
NPPs	National Priority Programmes
NRVA	National Risk and Vulnerability Assessment
ODA	Official Development Assistance
OECD	Organisation for Economic Co-operation and Development
PRTs	Provincial Reconstruction Teams
PTRO	Peace Training and Research Organization
STR	Student to Teacher Ratio
SWAps	Sector Wide Approaches
TTC	Teacher-training Colleges
TVET	Technical and Vocational Education Training
UDHR	Universal Declaration of Human Rights
UNDAF	United Nations Development Assistance Framework
UNDP	United Nations Development Programme
UNICEF	United Nations Children's Fund
U5MR	Under-five Mortality Rate
WASH	Water, Sanitation and Hygiene
WFFC	World Fit for Children
WFP	World Food Programme
WHO	World Health Organization
WSG	Water and Sanitation Group

Executive Summary

Afghanistan's last Situation Analysis of Children and Women was conducted in 2003. The country was just then emerging from Taliban rule and beginning the 'arduous process of rebuilding the nation'. Following thirty years of conflict, much of Afghanistan's infrastructure was destroyed and its public service structure was in shambles. The last ten years have focused on revitalising some of those debilitated social systems and establishing new ones to protect, educate and improve health care for Afghan children and their mothers. Despite challenges, remarkable progress for women and children has been achieved. Today the chances of survival for women and children have increased considerably. More children and adolescents, particularly girls, are enrolled in school at all levels and a majority of families have access to clean, safe water.

These improvements have seen Afghanistan advancing up UNDP's Human Development Index rankings; however, much work remains to be done. Analysis of available survey data demonstrated that tremendous gains were recorded in key indicators of well-being during the first half of the 2000s. But the pace of progress has tapered off and the last five years have recorded very modest gains. Progress, so far, has been uneven, benefitting mostly areas that are easier to reach. Those living in rural, remote areas or insecure provinces and districts were bypassed by government and NGO-provided services. This has created stark disparities between the rich and the poor, regions and provinces and urban and rural localities. Provinces such as Nooristan, Urozgan, Sari-Pul and Ghor continue to be among those provinces with the most deprivations in indicators of child well-being, while Kabul Province remains the least deprived. As the country moves towards the Transformation Decade (2015-2024) it is imperative that the gains made in the last decade are sustained and expanded. A focus on providing services to each community and ensuring that the community members themselves are involved in the design and monitoring of services will help accelerate progress, resulting in a sharper reduction of disparities. Ensuring equity in progress and reducing gaps between social groups will be the best way to promote a peaceful future for Afghanistan. The consequences of inequality are too great to ignore.

All actors, not just the Government, play a critical role in ensuring that the most vulnerable and deprived have the same opportunity to access services as those living in Kabul. There needs to be increased willingness to work with communities in hard to reach areas in order to deliver quality services. The people of Afghanistan live with a myriad of vulnerabilities and the ability to cope with these has weakened due to conflict and migration. The country needs an integrated and holistic approach to reinforce Afghans' resilience and address their multiple overlapping vulnerabilities. The piecemeal and unbalanced approaches, which do not address the root causes that have characterized the last decade, are not enough to bring about lasting change. The country, dependent on external support, needs the commitment of its development partners to ensure continued and increased support to social services over the next decade.

Women and children, particularly girls, have faced the worst during the conflict but attention to their rights continues to remain low. In 2004, Afghanistan had the 25th highest under-five mortality rate in the world with 121 deaths per 1,000 live births. Today, at 99 deaths per 1,000 live births, nearly twenty per cent more children are reaching their fifth birthday. This is a commendable achievement. However, progress has been slower than in most parts of the globe. In 2012, Afghanistan was ranked number 18 among countries with the highest under-five mortality rate. Most of the progress in reducing deaths among children has been after the age of one. Infant and neonatal mortality have shown only modest reductions.

Efforts to prevent deaths of pregnant and new mothers have yielded more significant results. In 2005, some 710 mothers per 100,000 live births were dying during pregnancy, delivery or soon after due to complications. Seven years later, mothers have a 33 per cent higher chance of survival. The country reduced its maternal mortality ratio (MMR) significantly, going from the 15th worst country in the world in terms of MMR to the 22nd worst. Early childbearing significantly risks the life expectancy of adolescent girls – the youngest first-time mothers face the highest risks of maternal morbidity and mortality. Afghanistan has also made significant progress in reducing its adolescent fertility rate. In 2004, the country had an adolescent fertility rate of 137, ranking it 13th in the world. By 2011 the rate was reduced to 93, taking it to 26th rank.

Diarrhoeal, respiratory and other infections are still among the biggest killers of children in Afghanistan. Access to immunization, to quality neonatal and child health care, the nutritional status of children, caring practices of the family, access to safe drinking water and adequate sanitation are all factors that influence under-five mortality in Afghanistan. Vaccination programmes, and provision of safe drinking water and sanitation have helped safeguard children's lives against preventable diseases. The country has already achieved its MDG target for safe drinking water. Just over half of all children are immunized against measles and the number of polio cases remained

low. Sanitation, however, has remained dismal with just about one-third of the population using improved sanitation and a significant divide remains between urban and rural areas.

Increase in survival rates among mothers and their children can be attributed to expanded access to health care services, and its greater uptake. The introduction and subsequent extension of the Basic Package of Health Services (BPHS) has meant that women and children are able to receive maternal, newborn and child health (MNCH) services such as antenatal care, skilled birth attendants, and vaccinations for newborn children. Starting from a low base, the early years of the BPHS saw a record growth in access. However, as the programme matured, its reach to underserved areas has slowed. It is not enough to put a health care delivery system in place without ensuring that the most vulnerable get proper and timely care. Ensuring treatment for the marginalized entails exploring innovative ways to reduce urban-rural and provincial disparities by addressing key geographic, poverty and social norm barriers that exist. This includes looking at ways to reinforce outreach services, and supporting and strengthening a cadre of the community health workers who can provide preventative services like immunizations and facilitate referrals to facilities.

Malnutrition is another significant contributor to disease and death among Afghan children. The country has a rate of stunting among under-five children at 40.9 per cent. The causes are complex and can range from food insecurity due to poverty or crop failure, to poor practices in feeding infants and young children. Malnutrition not only has health consequences, it also affects a child's education and participation in activities. Nutritional status impacts on students' concentration, school performance and learning abilities. Given the important role that nutrition plays in the lives of children, young people, and mothers, more attention needs to be paid to ensure all children are well nourished and healthy.

The Government of the Islamic Republic of Afghanistan and its partners have invested significant resources to rebuild the country's education system. The country achieved unprecedented success, moving from a point where only one million children (almost all boys) were enrolled, to a stage where 8.6 million children are now enrolled in schools, 39 per cent of them girls. To make this a reality, the Government and its partners have established nearly 15,000 schools and increased the number of teachers ten-fold from 20,700 (almost all male) to over 207,000 (34 per cent female). Efforts have also been made to improve the quality of education standards by introducing a national curriculum that promotes active learning methods.

Despite these achievements, the education sector continues to face significant constraints in achieving the Millennium Development Goals and the Education for All goals. About 3.5 million school-age children are still out of school, around 75 per cent of them girls. Working children, children living with disabilities, over-aged children and children affected by conflict are among those who are often denied their right to education. The uneven distribution of schools and alternative educational centres, and an inflexible curriculum and school calendar exacerbate enrolment problems in many areas and among many groups. Even for students who attend classes, the level and quality of education remains low and their achievement is unsatisfactory especially in the early grades. The high illiteracy among rural



adults also remains an obstacle to improved access and retention in schools which is often associated with misunderstandings about the value of education especially for girls.

Access to social services is hampered by poverty, insecurity, geography, and conservative social norms. In spite of the good progress, indicators on health and education point to girls and women being particularly disadvantaged. Notwithstanding the commitment to gender equality and women's empowerment articulated in policies and strategies, their translation into reality remains slow. Women and girls continue to be systematically under-represented in the decision-making processes that shape their future and that of Afghan society. Efforts to further improve their status need to be redoubled if sustainable development is to be achieved.

Family structures in Afghanistan offer a natural protective environment for children. However, the social norms that guide parenting practices sometimes undermine the healthy development of children and reinforce gender imbalances and entrenched structural inequities. Women and girls often face social barriers in their access to education, health care, livelihoods and protection. Their lives continue to be shaped by harmful practices such as forced and early marriage, 'honour killings' and *baad*. Some girls escape from these traditional pressures by running away. However, if they are caught, they often face criminal charges. The restrictive nature of girls and women's lives means that many women are not able to work. This combined with high poverty rates means that many boys often need to work in order to help support families.

Violence against women and children, including sexual violence, is believed to be widespread in Afghanistan. But perceived stigmatization, inadequate protective services and legal options means that violence, abuse, exploitation and neglect often go unreported and unaddressed. The nascent system and *ad hoc* approach to protection has meant that displaced children, street-children, children in conflict with the law and sexually and commercially exploited children do not receive adequate protection, care or support. Growing up in the midst of conflict has had serious repercussions for children and young people in Afghanistan. All parties to the conflict have recruited and used boys under the age of 18 years. Many children join because they have few other economic alternatives. Children involved with armed groups are often doubly victimized. Detained on national security related charges, they are held for indefinite periods of time in detention facilities. Judicial proceedings against such children should, in fact, treat them as victims first.

Children were also killed by the use of explosive weapons in populated areas, and by airstrikes. An overwhelming majority of civilians killed by explosive remnants of war (ERWs) are boys outside of the formal education system, tending to livestock, collecting firewood, or seeking to earn their livelihood through the collection of scrap metal. The conflict has had a profound impact on the well-being of children in Afghanistan. The country's capacity to respond and protect children, including their psycho-social health, is severely lacking and needs concerted attention in the immediate years to come.

In the development of Afghanistan, there needs to be much more focus on the rights of children and women. They continue to suffer from lack of opportunities – to participate, to be educated, to be healthy, and to be protected. It is vital that all stakeholders broaden their vision for Afghanistan beyond 'good enough', where easy gains are achieved through reaching the 'low hanging fruit'. This approach, though it has yielded very significant achievements, has also resulted in significant gaps separating social groups and widening inequities. If these gaps and inequities remain unaddressed the prospects for peace will be undermined. The past approaches will no longer suffice; innovations on how to reach the most vulnerable are needed. The Government and development partners need to continue and even intensify technical and financial support to ensure that all children and women benefit from progress.

There needs to be renewed attention and commitment to promoting and protecting human rights, particularly child rights. While reducing income poverty and improving the economy are important aspects of development, reducing development to just one factor – income – will limit development prospects. Excessive attention to reducing income poverty at the expense of extending rights-based social policies will undermine peaceful and sustainable development. There needs to be a more balanced and nuanced approach. Root causes of inequity limit opportunities of certain groups and must be addressed coherently by social policies as well as in other national policies and programmes. This is necessary to reduce inequality and foster a more stable and prosperous Afghanistan.

Introduction

Afghanistan is undergoing a security transition with the drawdown and potential exit of international military forces by the end of 2014. The three international conferences held - Chicago, May 2012; Kabul, June 2012; and Tokyo, July 2012 - have helped in bringing coherence to the transition strategy and process. At the Tokyo conference, focusing on Development, the Government produced a paper *Promoting Self Reliance in Afghanistan* outlining the priorities for the decade after 2014.

Through this Situation Analysis of the rights of children and women, a key input into the UNICEF Country Programme Action Plan, UNICEF aims to fill a critical gap in analysis. Based on this, it will provide recommendations to the Government and to development partners on how to devise a sustainable agenda for Afghanistan's development, balancing the needs for human and economic development. The analysis will also aid in formulating UNICEF's next country programme towards this goal. It should be noted that this analysis also considers select women's rights that have a bearing on the realization of children's rights.

This Situation Analysis aims to provide a comprehensive evidence-based analysis to help identify not only successes but also critical gaps and obstacles to realizing the rights of children and women in Afghanistan. The persistence of disparities between groups and multi-dimensional poverty are critical child rights concerns. The objective of this analysis is to promote a rights-based approach in order to achieve sustainable human development. It is guided primarily by the Convention on the Rights of the Child (CRC), ratified by Afghanistan in 1994, and its four core principles: non-discrimination; the best interest of the child; the right to life, survival and development; and respect for the views of the child. Other key reference points are the Millennium Declaration and the Millennium Development Goals, international human rights conventions (including the Convention on the Elimination of All Forms of Discrimination Against Women), and the Core Commitments for Children in Humanitarian Action that lays down UNICEF's commitments to children in emergencies.

Methodology

In order to ensure that the Situation Analysis remains rights-focused, rather than being based on analysis by sector or by intervention, the scope of analysis considers four key areas of development based on the Millennium Development Goals (MDGs) and the World Fit for Children (WFFC): maternal mortality; under-five mortality; access to quality primary

education; and protecting children from violence, abuse and exploitation. These are not just development challenges but fundamental human rights issues.

Each of these issues has undergone a 'causality analysis' – a vital analysis to inform human rights-based development work. It draws attention to root, underlying and immediate causes of rights deprivations, thereby helping to identify the systemic patterns of discrimination that perpetuate poverty and vulnerability. This serves to demonstrate the inter-related nature of children's and women's rights, and how efforts to safeguard and fulfil them involve a multi-sectoral, holistic effort that rises above the specific interests of a particular development sector, international agency or government ministry. The causality analyses bring out not only the most urgent priorities for action in tackling a particular problem, but also how efforts in other sectors contribute directly or indirectly to sustainable progress.

Following the causality analysis, the Situation Analysis lays out the wider context for development efforts in Afghanistan as of 2013. It focuses on key risk factors affecting children and women, including poverty, underemployment, natural disasters, conflict, migration and urbanization. It also examines the social norms, particularly in relation to gender roles and pre-conceived notions of childhood that often clash with a rights-based development agenda. Finally, it considers the institutional framework within which development takes place from the Government's strategic objectives to its fiscal approach and capacity constraints, from social policy to the dynamics between the formal legal system and customary law.

The Situation Analysis then goes into a more detailed examination of each of the four main areas of social sectors: child protection; health and nutrition; education; and water, sanitation and hygiene. Each of these sectoral reports has a common structure, looking first at the vital indicators and trends, and then moving on to consider key strategies, key programming approaches, budgetary issues, human resources and demand-side barriers. Finally, it identifies the most important strategic areas for action.

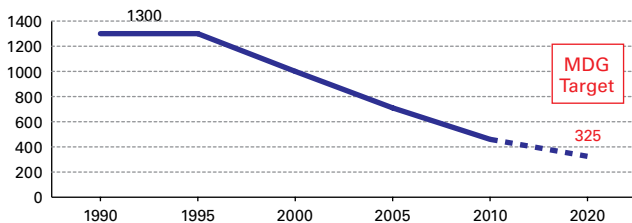
The Situation Analysis concludes by laying out the overall strategic areas for action. Understanding the existing obstacles to fulfilling children's and women's rights, it better equips UNICEF and its partners to address these violations and improve outcomes for children in the next critical period of transition and the continuing development of Afghanistan.

Progress towards the Millennium Development Goals (MDGs)

Although Afghanistan is not likely to achieve most of the MDGs in 2020 due to high levels of maternal and child mortality and persisting low levels of access to basic social services, significant progress has been made towards many of the indicators (see Annex 1).

Remarkable progress has been made in reducing the number of maternal deaths – which plummeted from 1,300 per 100,000 live births in 1990 to 460 in 2010. The average annual rate of reduction (AARR) required between 1990 and 2010 for Afghanistan to reach its MDGs by 2020 was 6.7 per cent, far surpassing the required AARR of 3.4 per cent to achieve the target of 325 in 2020. However, in spite of the substantial reduction in the death toll between 2002 and 2006, the trend has slowed down or even stagnated between 2007 and 2011.

Figure 1 Trends in Maternal Mortality Ratio (1990-2020)

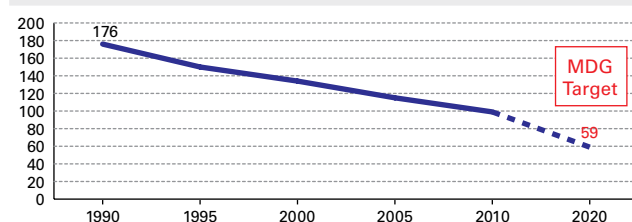


Source of data: WHO. Maternal Mortality 1990 to 2010: WHO, UNICEF, UNFPA and the World Bank Estimates. 2012

An effective measure to reduce maternal and newborn deaths is increasing the number of births attended by skilled health personnel. Between 2007/08 and 2010/12 a significant increase of 16 percentage points in the proportion of births attended by skilled health personnel was observed. However, the rate still remains low at 40 per cent. There is also a big difference in the level of coverage among regions, the highest being in the Central Region (64 per cent) and lowest in North East Region (17 per cent).

Under-five mortality rates in Afghanistan have dropped over the last 22 years, from 176 per 1,000 live births in 1990 to 134 in 2000 and 99 in 2012. This represents a significant achievement. However, it will still be a challenge to achieve the MDG target. The rate of reduction of under-five mortality has slowed during the period from 2000 to 2012 to an average annual rate of reduction of 2.5 per cent. Achieving the MDG for child mortality requires an annual reduction rate of 6.3 per cent.

Figure 2 Trends in Under-five Mortality Rate (1990-2020)

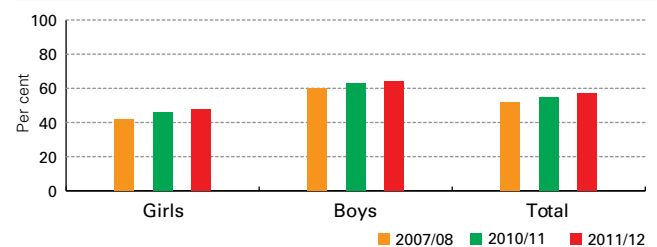


Source of data: UNICEF. Levels and Trends in Child Mortality: Report 2013
Estimates Developed by the UN IGME. 2013

Child immunization is one of the key interventions to reduce infant and under-five mortality rates. Measles coverage rate, the proxy indicator to measure full immunization coverage of children before reaching the age of one, has remained unchanged between 2007/08 and 2010/11, at a low 56 per cent.

The progress in education in Afghanistan over the last 12 years could hardly have been more dramatic. In 2001, only one million children were in school and almost all of those were boys. Today, 8.6 million children are enrolled in formal schools at all levels and nearly 39 per cent of them are girls – an unprecedented transformation for the country's national provision of education. Seventy per cent of all children enrolled, around 5.3 million, are found in primary schools with girls accounting for 40 per cent of primary school students.¹ The proportion of primary school age children attending school is still low at 57 per cent (64 per cent for boys and 48 per cent for girls).

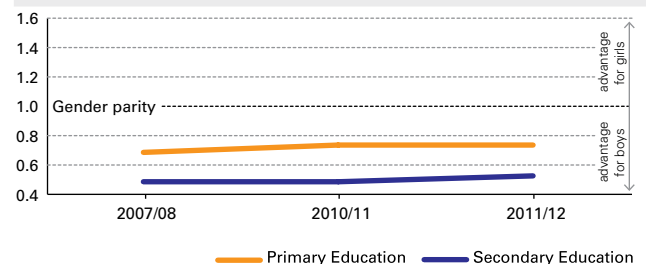
Figure 3 Trends in Primary School Attendance Rate (2007/08 - 2010/11 - 2011/12)



Source of data: National Risk and Vulnerable Assessment (NRVA) 2007/08, Afghanistan Multiple Indicator Cluster Survey (MICS) 2010/11 and NRVA 2011/12

Afghanistan made significant progress to increase children's access to primary education especially for girls. The gender parity index increased from 0.69 to 0.74 between 2007/08 and 2011/12. The gender parity index is the ratio of girls to boys in primary education. For the gender equality ratio in primary education, comparatively more girls are attending school when the ratio is over 1.0 and comparatively more boys when it is under 1.0. Progress has also been made in secondary schools; the index was 0.49 in 2007/08 and increased to 0.53 in 2011/12.

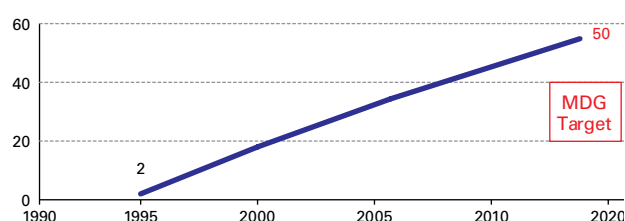
Figure 4 Trends in Gender Equality in Education (2007/08 - 2010/11 - 2011/12)



Source of data: NRVA 2007/08, MICS 2010/11 and NRVA 2011/12

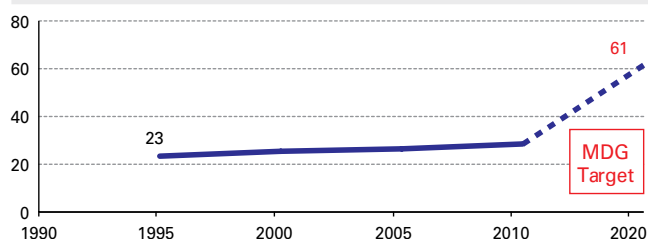
Between 2000 and 2011, the proportion of the population using improved drinking water sources increased substantially from 22 per cent to 61 per cent; the proportion of the population using an improved sanitation facility increased moderately from 23 per cent to 28 per cent based on the The World Health Organization's (WHO) and UNICEF's Joint Monitoring Programme estimates. Afghanistan has already met its national 2020, MDG drinking water target of 50 per cent; reaching its MDG sanitation target of 61 per cent remains a challenge.

Figure 5 Trends in the Proportion of Population Using an Improved Drinking Water Source (1995-2020)



Source of data: WHO/UNICEF Joint Monitoring Programme. Progress on Sanitation and Drinking Water: 2013 Update. 2013

Figure 6 Trends in the Proportion of Population Using an Improved Sanitation Facility (1995-2020)



Source of data: WHO/UNICEF Joint Monitoring Programme. Progress on Sanitation and Drinking Water: 2013 Update. 2013

Progress towards the MDGs among eight regions

Afghanistan has 34 provinces grouped into 8 regions (see Map 1). Trends of regional progress toward MDGs based on available and comparable data are presented in Annex 2.

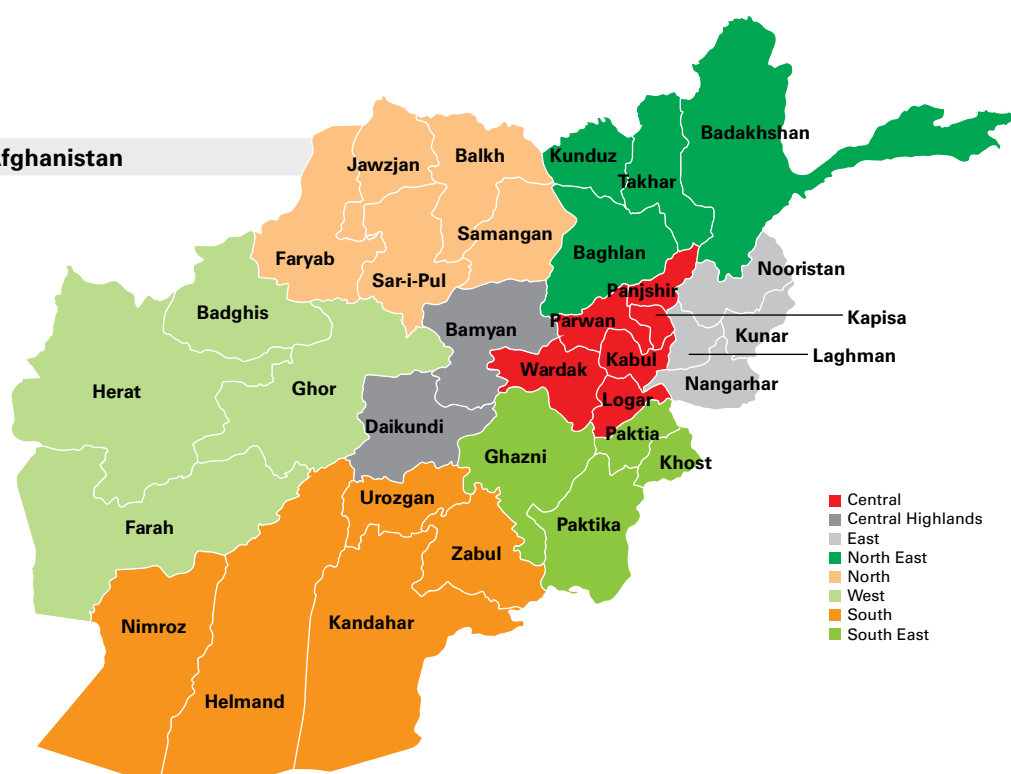
Although some progress has been made towards the MDGs at the national level, progress at the regional level has been uneven. There are great disparities between regions in the level of access to basic social services.

The net attendance of primary education is low across all eight regions. It is highest in the Central Highlands Region (87 per cent) and lowest in the South Region (19 per cent). All regions except for the North East Region have made significant progress to increase primary school attendance between 2007/08 to 2011/12. The North East region, however, has shown no change.

No region has achieved gender parity in primary education (a ratio of 1.0 signifies parity). The Central Highlands Region has the highest ratio (0.92) while the South East Region has the lowest gender parity (0.50). Between the survey years 2007/08 and 2011/12, the Central, Central Highlands, North and South East Regions have made significant progress to improve gender parity in primary education between 2007/08 to 2011/12. The East, South and West Regions, however, have shown no change.

In 2010/2011, the measles rate was low in all regions. The Central Region had the highest rate (70 per cent) while the South Region had the lowest rate (19 per cent). Only the Central Highlands and West Regions achieved significant increases of measles coverage rates, while the Central, East, North East, and South East Regions remain unchanged. North and South regions saw a significant reversal of measles coverage rate between 2007/08 and 2010/11.

Map 1 Regions in Afghanistan



All regions, except for the Central Highlands and the South have made significant progress in increasing the coverage rate of population using an improved drinking water source. Central Region has the highest rate (63 per cent) while Central Highlands has the lowest rate (20 per cent). Central Highlands and South Regions show no significant change between 2007/08 and 2011/12.

Child Deprivation Indices

It is important to prioritize children when crafting the development agenda of a country. Hence, policy-makers must reflect upon possible multiple deprivations that children face with respect to education, health, nutrition, protection issues and living standards. In relation to this, it is necessary to formulate better measures and indicators that accurately monitor the state of children.

Considering the socio-economic situation and available data in Afghanistan, 12 indicators in five dimensions (child development, reproductive health, child health, child nutrition, and household environment) were selected to conduct the statistical test for correlation with poverty using the National Risk and Vulnerability Assessment (NRVA) 2007/08 and 2011/12 data (see Annex 3).

Reproductive health recorded the most gains over the five year period. In 2007/08 only 18 per cent of reproductive age women were not deprived of reproductive health services, i.e. they had some antenatal care and birth was attended by skilled health personnel. In 2011/12 this percentage rose to 24 per cent.

Improvement in child development and household environmental conditions recorded more modest gains. The percentage of children deprived of child development was 61.3 per cent in 2011/12 down from 62.3 per cent in 2007/8. Deprivation of a healthy household environment showed a slight decrease of 2.1 percentage points between 2007/08 and 2011/12. However, deprivation of a healthy environment, defined as lack of sanitation, safe water and poor housing is nearly universal at 96 per cent and can have serious consequences for children's health and well-being.

The nutritional status of children continues to be an area requiring attention. In 2007/08 35 out of 100 children did not receive Vitamin A supplementation, this decreased from 33 to 35 out of 100 children in 2011/12. This puts children at risk of developing Vitamin A deficiencies which can be an underlying cause of illness and death. For instance, Vitamin A deficiency is a well-established risk factor for measles-related mortality. Increasing the level of Vitamin A supplementation can help accelerate progress towards MDG4. The proportion of children under-five deprived of child health interventions, i.e. child immunization, was staggeringly high at 84 per cent in 2007/08. No data on deprivations related to child health was available for 2011/12 at the time of the CDI analysis.

Progress towards fulfilling children's rights is uneven across the country with significant disparities between provinces

and between rural and urban areas. The Child Deprivation Indices (CDI) were generated for each of Afghanistan's 34 provinces. Further clustering analysis was performed, rather than ranking, in order to identify provinces that are falling

Table 1 Results of Child Deprivation Index

Dimension	Not deprived Moderately Deprived		Deprived				Number of Indicators ^{1/}
			Severely Deprived	Moderately Deprived	Severely Deprived		
	NRVA 2007/2008	NRVA 2011/2012	NRVA 2007/2008		NRVA 2011/2012		
Child Development	37.7	38.7	57.0	5.3	56.0	5.3	4
Reproductive Health	17.6	23.9	20.5	61.9	16.6	59.5	2
Child Nutrition	67.2	65.3	32.8		34.7		1
Child Health	15.8	a	84.2		a		1
Environment	1.9	4.0	25.8	72.3	42.1	53.9	4

Note: 1. Indicator on children under 5 without DPT3 vaccine is not available in NRVA 2011/2012.

behind in child rights and require urgent attention to make progress. Three clusters were identified, with cluster 1 indicating the worst group of provinces and cluster 3 indicating the least deprived group of provinces in accordance with the CDI methodology. The maps below show the clustering of provinces for all five of the CDIs.

Urozgan, for instance, belongs to cluster 1, or the most deprived group of provinces. While the data indicates that improvements in deprivations have occurred in Urozgan between 2007/08 and 2011/12, the province continues to have some of the worst indicators of child deprivation across all five categories/dimensions. About 7 out of every 10 children in Urozgan were either deprived or severely deprived in child development. This shows a slight improvement over 2007/08 when 8 out of 10 children were deprived of child development. Nearly 100 per cent of women were severely deprived of and all children were deprived of healthy environmental conditions.

Between 2007/2008 and 2011/2012, the provinces of Badghis, Helmand, Ghor, and Kapisa were among the lowest. In Badghis, about 7 of 10 children were deprived of child development; all women were severely deprived of reproductive health; about 6 of 10 children were deprived in child nutrition; 9 of 10 children were deprived of child health; and all children were severely deprived of healthy household environment. In Helmand, most children were either deprived or severely deprived in child health and environment. Helmand saw improvement in reproductive health. In Ghor, most children were either deprived or severely deprived in reproductive health and environment. In Kapisa, most children were either deprived or severely deprived in reproductive health, child health and environment.

On the other hand, Kabul was better off in terms of child poverty

as the capital remained at cluster 3 or the least poor group of provinces between 2007/2008 and 2011/2012 in all five categories/dimensions, i.e., child development, reproductive health, child nutrition, child health and environment. Further, Wardak belongs to cluster 3 or the least poor provinces in three of the five categories/dimensions.

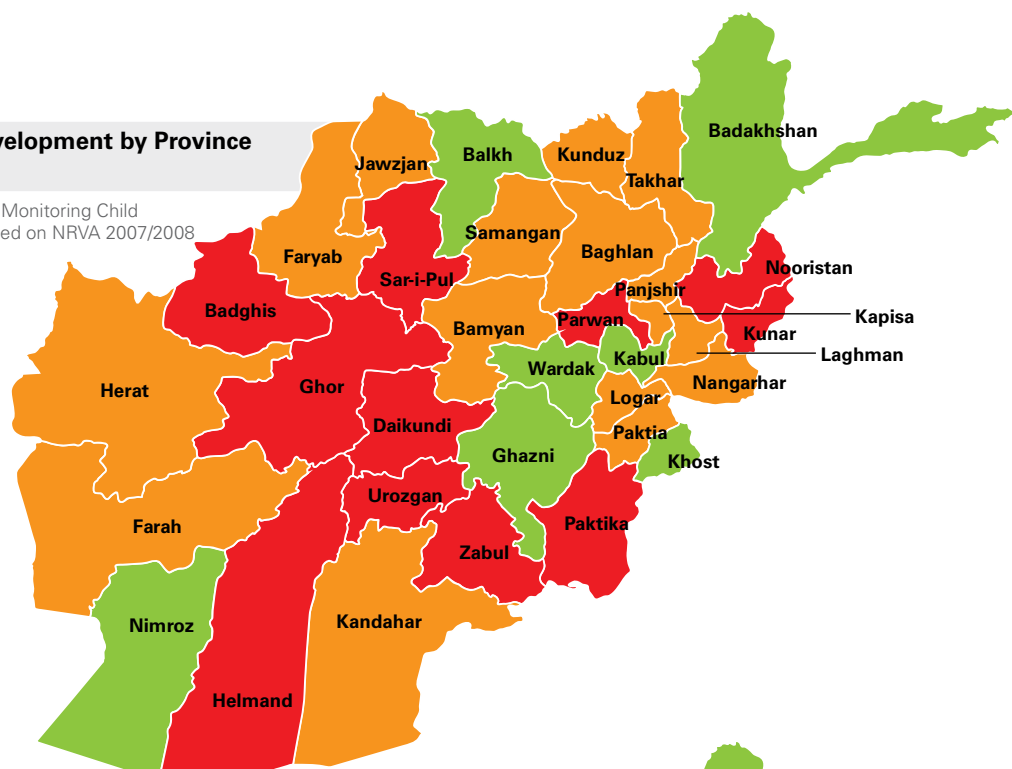
Planning for service delivery – at the national and local level – as well as monitoring results, requires information on population figures and trends. This means the Government needs to know how many girls, boys, women and men live in a certain area in order to deploy resources. For example,

it has to know how many children live in a province in order to know where to build schools and how many teachers to hire. Afghanistan has not had a population census for three decades, and use of the vital registration system is low. There are population estimates but these do not necessarily take into consideration population shifts and migration.

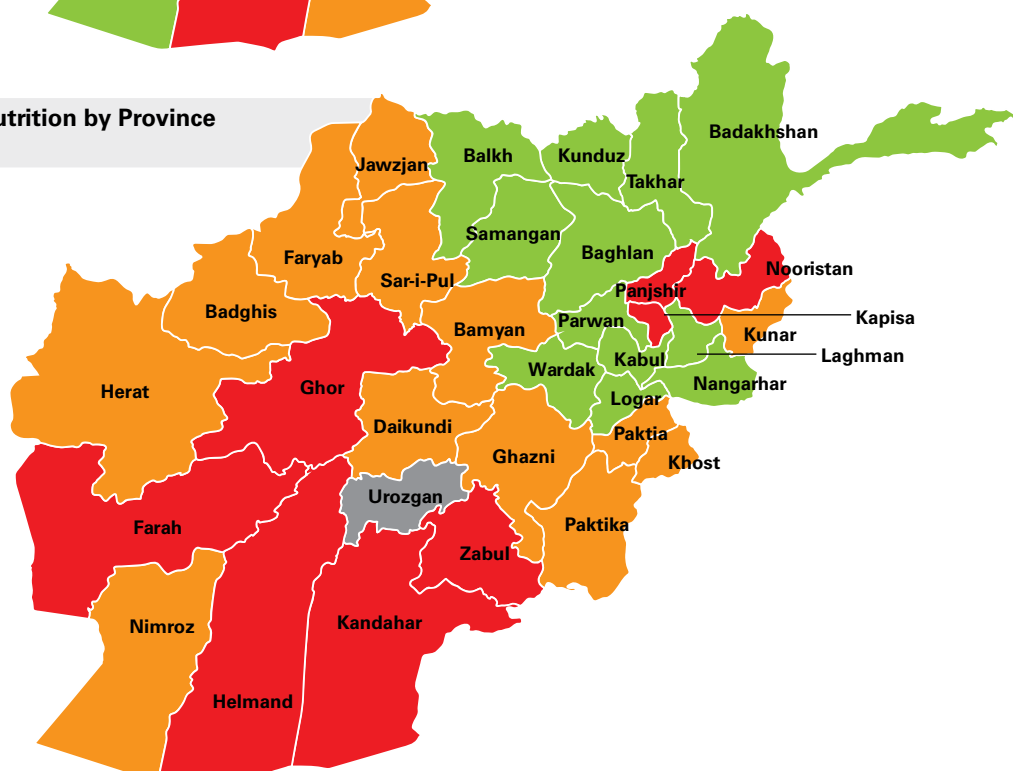
Efforts have been made to generate evidence on children's and women's issues through national surveys and routine data collection. Relevant indicators have been included in the NRVA, and MICS has been conducted. An Education Management Information System (EMIS) and Health

Map 2 Deprivations in Child Development by Province (2007-2008)

Source: Technical Report on Measuring and Monitoring Child Poverty in Afghanistan: An Examination Based on NRVA 2007/2008



Map 3 Deprivations in Child Nutrition by Province (2007-2008)

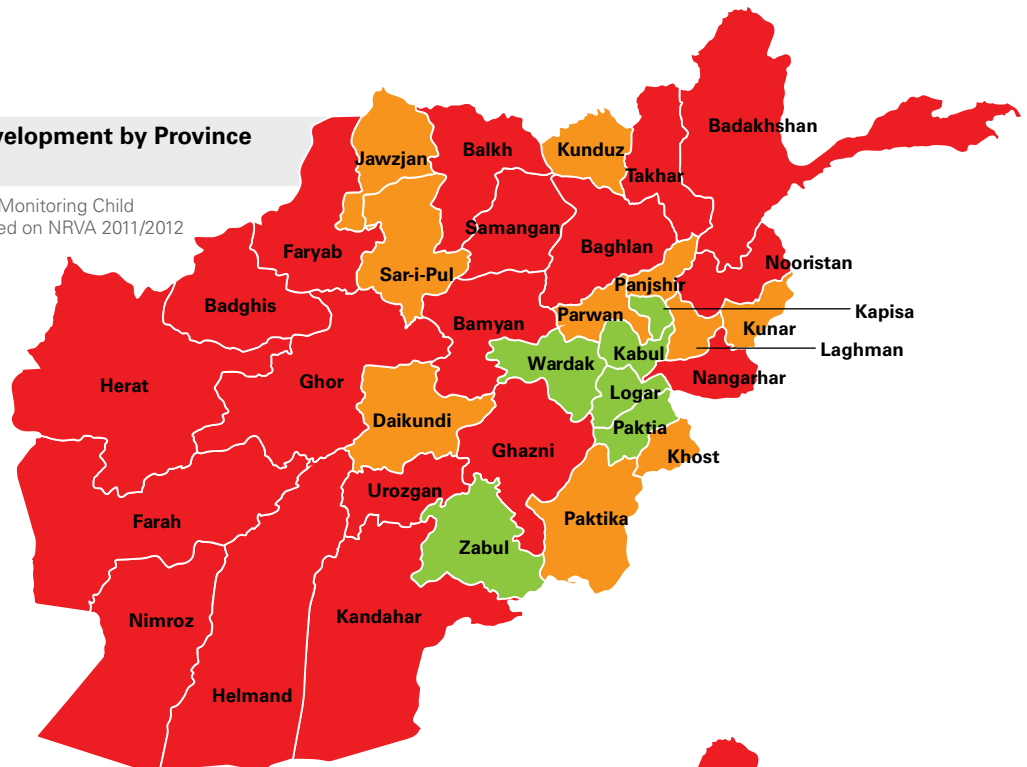


■ Severely Deprived
■ Deprived
■ Least Deprived

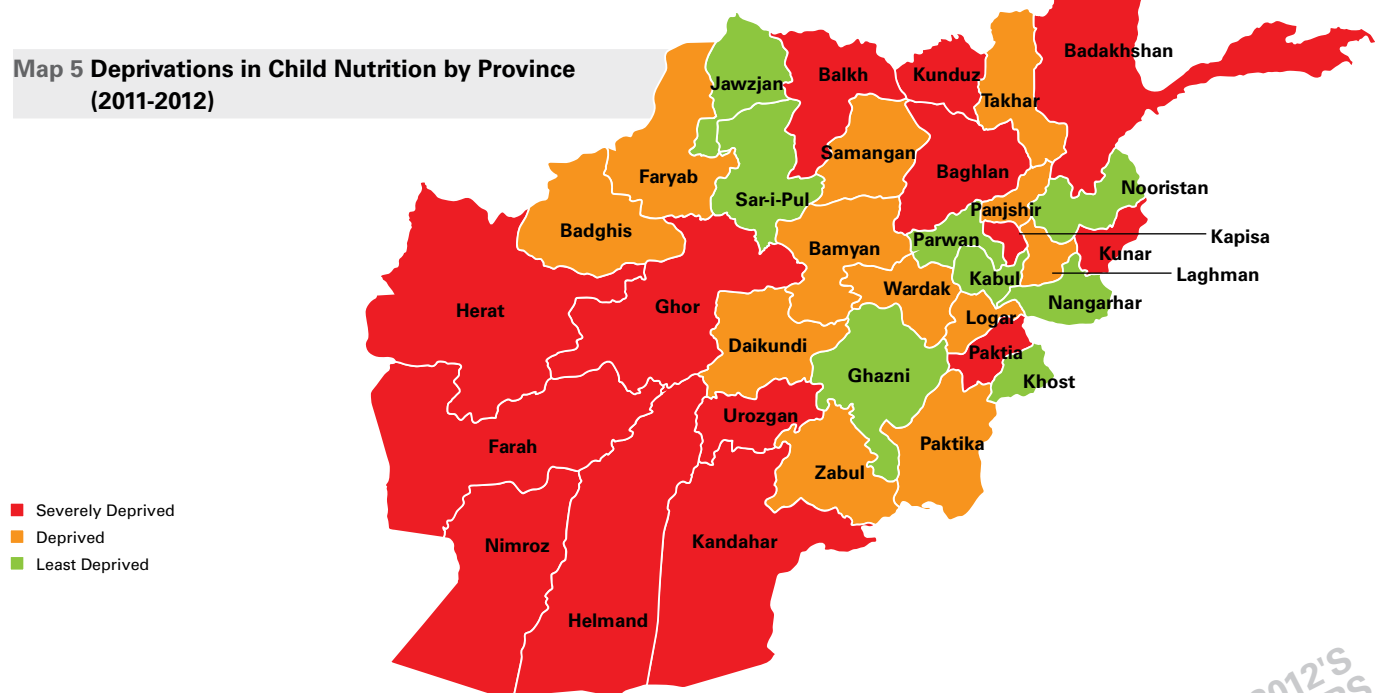
Management Information System (HMIS) have been established, as have other *ad hoc* monitoring mechanisms. However, challenges remain in how to ensure quality information is systematically collected and managed, and then translating data into policy and programming directions. Among factors contributing to the insufficient use and poor quality of data are the absence of a culture of evidence-based planning and decision-making, the storage and availability of data within management information systems, and weak capacity of the line ministries in analyzing and reporting data.

Map 4 Deprivations in Child Development by Province (2011-2012)

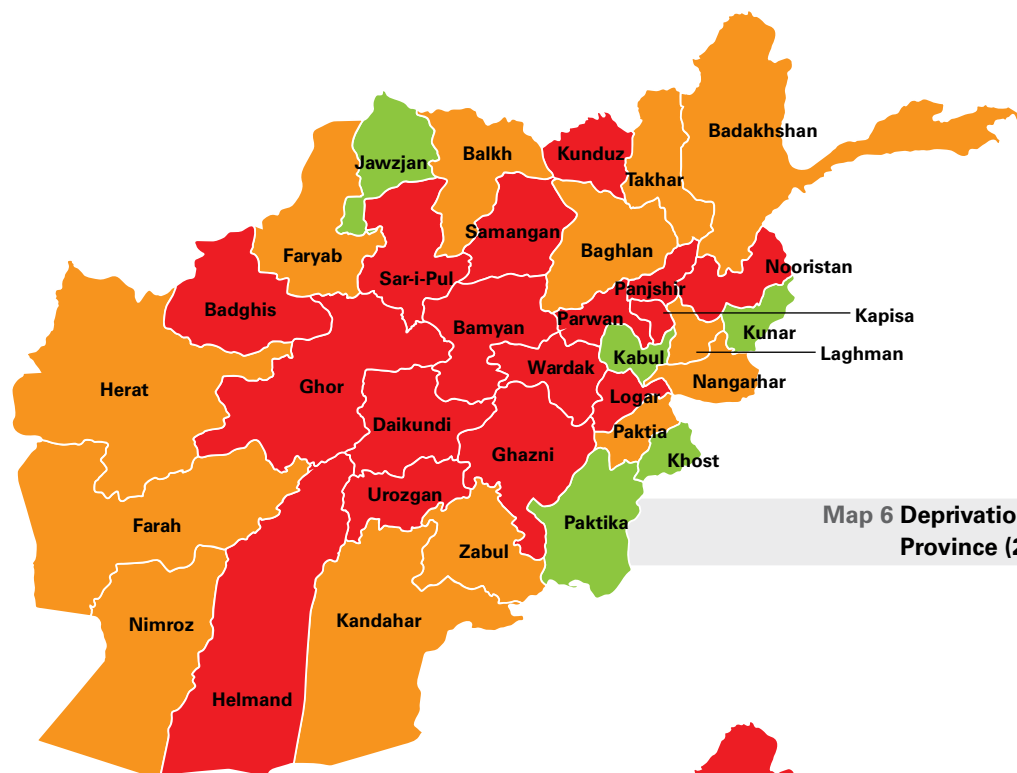
Source: Technical Report on Measuring and Monitoring Child Poverty in Afghanistan: An Examination Based on NRVA 2011/2012



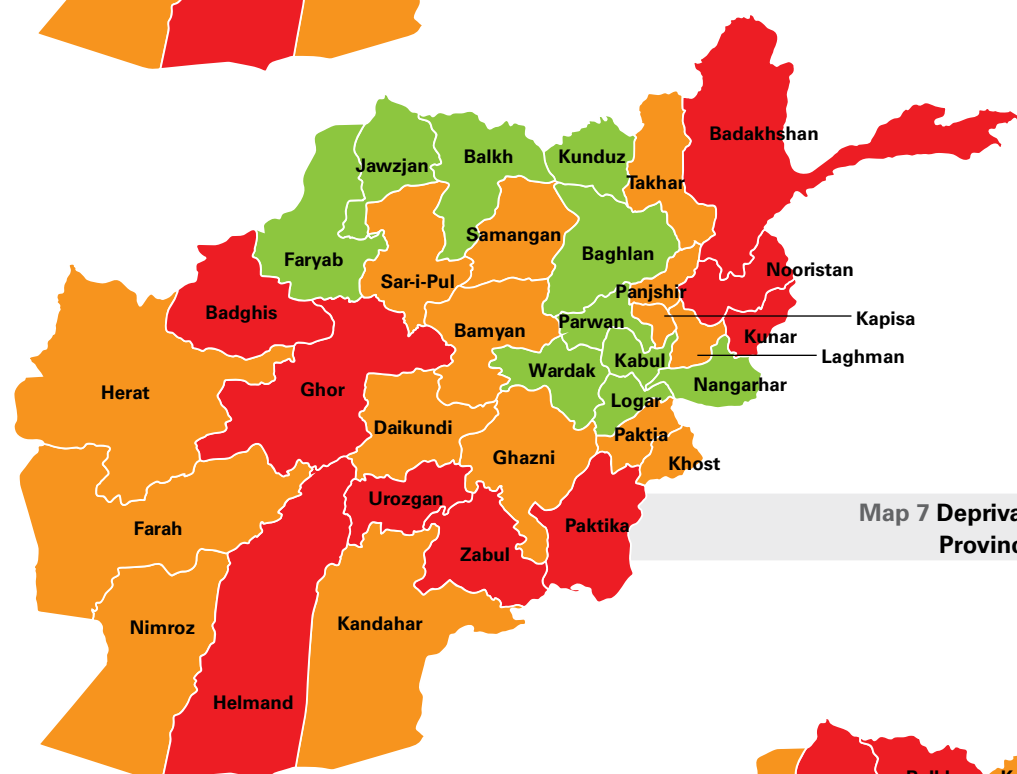
Map 5 Deprivations in Child Nutrition by Province (2011-2012)



■ Severely Deprived
■ Deprived
■ Least Deprived

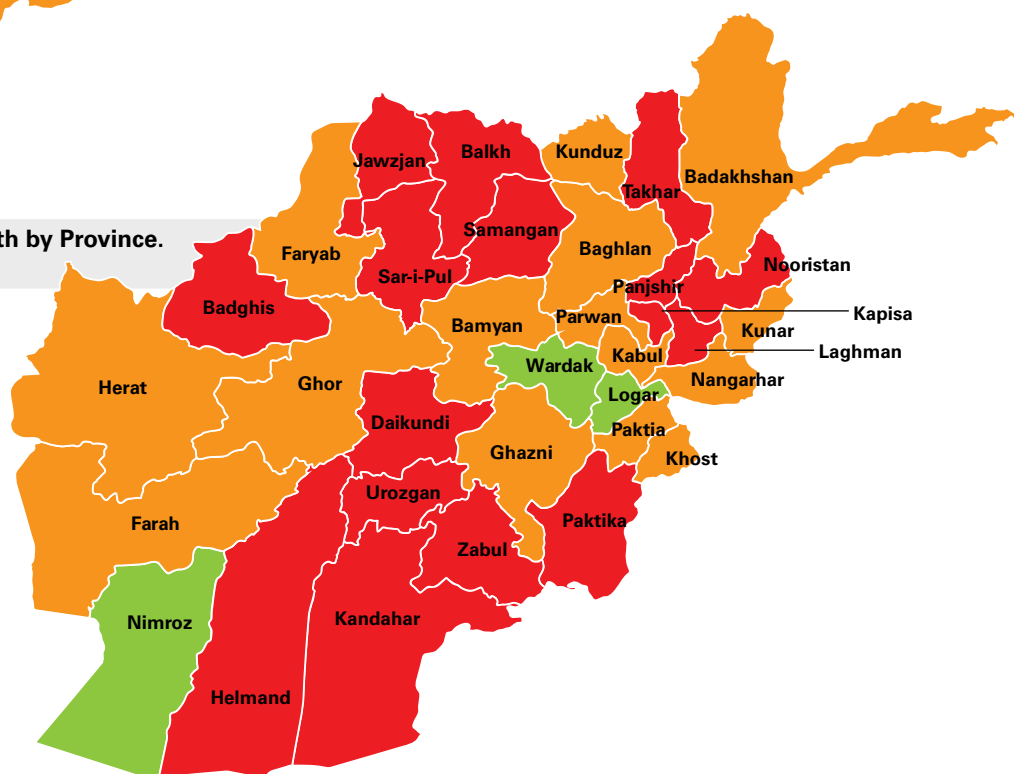


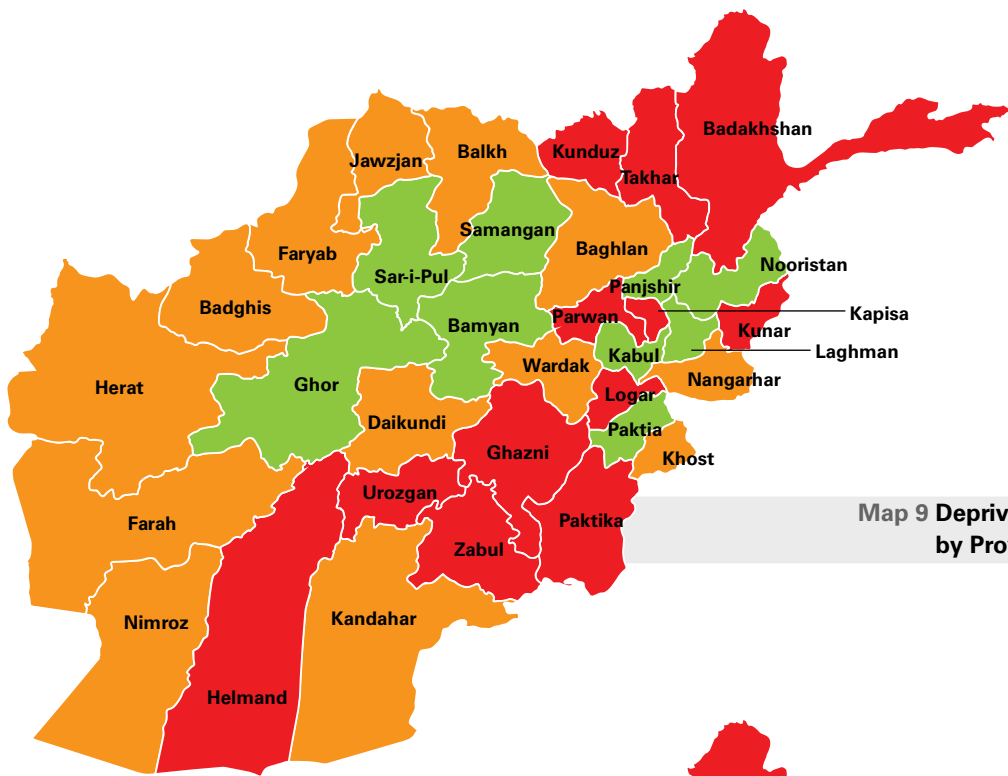
Map 6 Deprivations in Household Environment by Province (2007-2008)



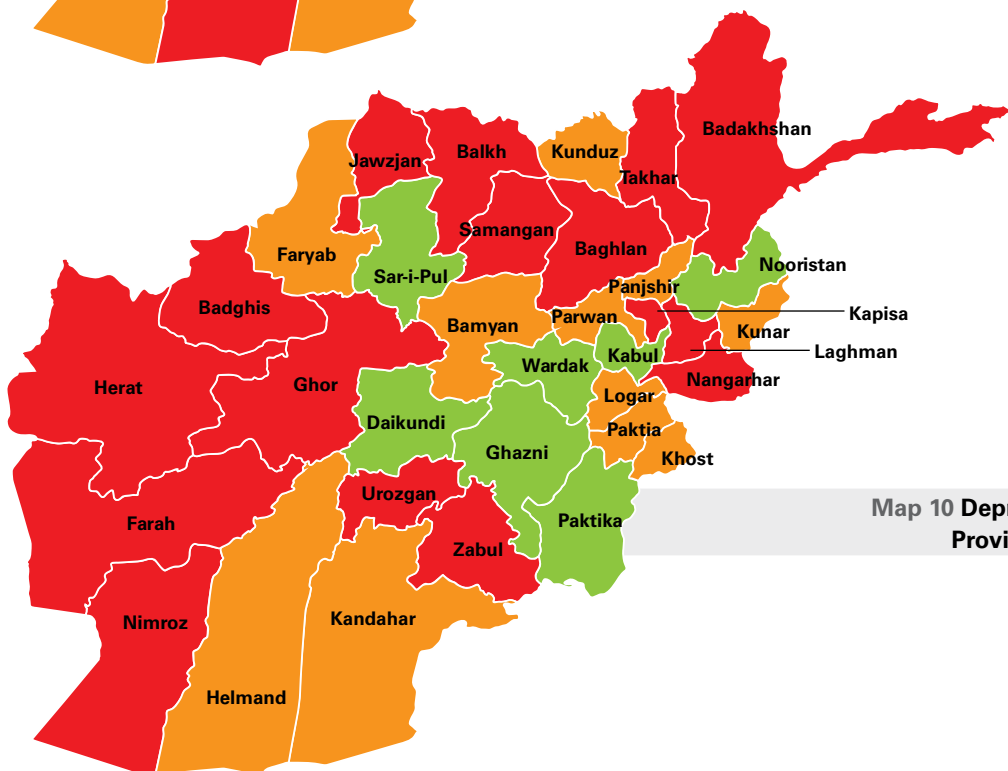
Map 7 Deprivations in Reproductive Health by Province (2007-2008)

Map 8 Deprivations in Child Health by Province. (2007-2008)





Map 9 Deprivations in Household Environment by Province (2011-2012)



Map 10 Deprivations in Reproductive Health by Province (2011-2012)

- Severely Deprived
- Deprived
- Least Deprived

Progress towards Child Rights in Afghanistan

Human and economic development in Afghanistan is stymied by widespread deprivation. This report aims to take stock of Afghanistan's level of achievement in protecting and promoting children's rights and to better understand the degree to which laws, policies, mechanisms and practices reflect international child rights standards. Ensuring that children's and women's rights are met and protected is an indispensable part of Afghanistan's future. It will increase the country's capacity to cope with the many challenges that currently afflict it, from poverty and underemployment, to natural disasters and conflict, to migration and urbanization.

This analysis should also assist the Government and stakeholders, including national and international NGOs, donors, and other UN agencies, to move away from a narrow construct of child well-being exemplified by a needs approach, to a broader rights-based view which enhances the realization of child rights. Child rights are linked to, yet distinct from, child well-being, with the latter being focused on the status of the child and the former looking at the relationship between the child, the state and society. Through a broad application of rights to the development discourse and the promotion of opportunities for children and adolescents, Afghanistan will be better positioned to sustain its development achievements and accelerate poverty reduction. Only through a review of what has been accomplished so far will we be able to identify the gaps and focus on what needs to be prioritized going forward.

In Afghanistan, the discussion on human rights continues to be linked to the rule of law and governance, confining rights to political and civic rights.² If social and economic issues are not a part of the rights discourse the impetus to provide services to all women and children in Afghanistan without bias or discrimination, and in a manner that promotes their best interest, may be removed. In such a situation the provision of social and economic services is not seen as a legal obligation but based on charity. It also means that children and their families are seen as passive recipients rather than active participants in their own development.

The Convention on the Rights of the Child (CRC) was ratified

without reservation by Afghanistan in 1994, committing the Government to protect, respect and fulfil children's rights. Several other international human rights instruments have been ratified.³ The Government of the Islamic Republic of Afghanistan (GoIRA) has taken a number of positive policy and legislative steps to move towards compliance with human rights instruments. The Constitution of Afghanistan (2004) provides for progressive guarantees of certain international human rights standards. The Afghanistan National Development Strategy (ANDS), the National Priority Programmes (NPPs) and various sectoral and cross-sectoral policies were drafted with human rights principles, including certain CRC provisions, endeavouring to build a more peaceful and just Afghanistan.

However, there are several factors that constrain the promotion of child rights. The GoIRA does not view the CRC as legally binding, and as such the full range of child rights has not been systematically incorporated into the legal system or domestic policy. There is little direct reference to the rights of children in the Constitution, in policy and legislative frameworks or national level policy dialogues. The Government and the international community have instead focused on meeting a select group of key targets guided by the MDGs through the provision of services.⁴ This has, in turn, led to a partial and fragmented approach in the realization of child rights. However, more children and women are having their rights to survival, education and clean water met. This can be evidenced through data presented in the earlier section. However, scant attention to the broader spectrum of rights and how they reinforce one another has meant that rights related to nutrition, sanitation, hygiene, protection and social safety nets are not promoted as strongly. This can be demonstrated by the low budget allocations given to these sectors by the Government and partners. There continue to be shortfalls in the convergence of policies and legislation on the CRC in implementation and effective coordination and monitoring.

Causality Analysis of Realization of Rights

The following four subsections will unpack the causality of the lack of realization of rights leading to the manifestations of

CHALLENGES TOWARDS IMPLEMENTATION OF THE CRC

In 2009 the Afghanistan UNCRC Civil Society Coalition published an Alternative Report on the Implementation of the Convention on the Rights of the Child. It highlighted several critical challenges towards the full implementation of the CRC in Afghanistan. The report identifies that leadership and coordination is fragmented as "the responsibility for the implementation of the CRC is shared between different ministries and departments" leading to "weak implementation of policies and programs for the best interests of the child". Progress towards fulfilling children's rights is not only due to this "lack of clarity around the roles and responsibilities" but also "a lack of... political will". The report also cites that "limited or no allocation of resources, mainly financial resources, presents further obstacles in the implementation of laws and policies".

Source: Afghanistan UNCRC Civil Society Coalition. Every Single Right for Every Single Child: NGO Alternative Report on the Implementation of the Convention on the Rights of the Child Afghanistan. October 2009.

high rates for maternal and child mortality inadequate access to quality primary education and persistent violence, abuse and exploitation of children. From the discussions of causality the interplay and interdependence of rights is clear. Failure to address even one of the rights will mean that development progress is untenable and incomplete.

Maternal mortality: The underlying causes of maternal mortality are: (i) delay in decision-making at the household level to seek health care once complications arise; (ii) delay in transportation from home to a facility that can manage the complications; and (iii) delay in providing appropriate emergency care to manage complications. Decision-making delays are often due to women's status in families and discriminatory norms related to seeking care of pregnant women, poor knowledge and lack of information on complications that can be life-threatening and poverty leading to families being unable to afford rapid means of transport. Long distances and inadequate transportation means that often, by the time a pregnant woman reaches a health facility, it is too late to save her or her baby. Even if she is able to reach the facility in time, there may not be appropriate staff or supplies available to provide appropriate care.

Child and early marriage, early sexual activity and premature childbearing are associated with significant risks for young girls.

All these factors that contribute to maternal deaths stem from structural human rights violations, including abuses of the right to education and to a decent standard of living. Women's rights to equality and freedom of movement are commonly violated and affect their access to health care services. In Afghanistan, social norms dictate that women need to be accompanied by a man on a journey out of her community, even to a health centre. And yet, men are often reluctant to take time off from work to accompany an expectant mother on such a visit. In all too many cases, however, the health care services to which women have a right are simply unavailable. Nevertheless motherhood and health care during pregnancy, delivery and the post-natal period are given special consideration in both the Universal Declaration of Human Rights (UDHR) and the Convention on the Elimination of Discrimination Against Women (CEDAW).

Afghan women have little control over reproductive health choices. Less than a quarter of women use contraception, with the result that Afghanistan has the seventh highest birth rate in the world, as well as very short spaces between births. Education can play a critical role here – women with no schooling are half as likely to use reproductive health services as those with secondary education; they are also less likely to employ contraception.

Child and early marriage⁵, early sexual activity and premature childbearing are associated with significant risks for young girls. Social norms around the acceptability and promotion of child and early marriage have resulted in 15 per cent of adolescent girls bearing children. There is also little space for girls to challenge the decision to marry, initiate sexual activity or to have children. These decisions are usually left to parents, husbands and in-laws.

The ongoing conflict in Afghanistan has had a particularly negative impact upon women's access to health care services. For example, women and their husbands may be deterred from visiting a clinic for fear of being detained by armed groups or by national forces. Alternatively, they may worry that a visit to a public clinic can be perceived as a gesture of support for the Government. The conflict has also brought about huge damage to infrastructure, including roads and systems of public transportation, as well as ambulance services. These factors inevitably mean increase in travel time for seeking health care.

Lack of adequate services remains a fundamental problem. Families have responsibilities when it comes to caring for pregnant women and young mothers, but the Government remains the key duty-bearer and is currently failing to provide sufficient resources to prevent maternal mortality and "ensure availability, accessibility, acceptability, and good quality of services."⁶ This not only means that far too many women are still dying unnecessarily, but also that lack of adequate and equitable services are helping to institutionalize gender discrimination.

Under-five mortality: A range of unfulfilled rights contribute to the high under-five mortality rate in Afghanistan. Children have special needs due to their being young and dependent on adults, and therefore have particular rights. As outlined by the Human Rights Council in 2013, the rights that directly bear on under-five mortality include those related to non-discrimination, identity, health, education, safe and nutritious food, and safe drinking water and sanitation. However, given that a majority of deaths occur within the first year of life, safeguarding mothers' rights is also essential if child mortality is to be reduced. Moreover, many of the rights violations that cause under-five deaths also contribute to maternal mortality.

The right to life is undermined by preventable diseases – most commonly by acute respiratory infections, other serious infections and diarrhoea, all of which are aggravated by the country's high prevalence of malnutrition. The underlying causes of these illnesses are inappropriate caring and feeding practices, unhealthy and unsafe environments, and poor access to health and nutrition services at the community level.

Inappropriate caring practices can contribute to increased rates of malnutrition and to incorrect treatment of illnesses. Children depend upon their parents to keep them healthy, and to seek treatment when they fall ill. They also pay the price when wrong practices are followed or wrong decisions made. Often these violations of a child's rights to life and health emerge out of previous abuses of their parents' own rights to education or the impact of harmful traditional practices on their mother.

Education – or rather the lack of it – plays a key part in the unhappy story of under-five deaths. The mother's level of education is the most important determinant that governs the success of any intervention in health and nutrition. An educated mother is more likely to avail herself of antenatal

care. Such a mother uses family planning, ensuring that a skilled attendant supervises the delivery of her baby, and she does not rely on traditional healing. She is also more likely to be aware of healthy feeding practices (what kinds of food to eat and when) and the need for hygiene within the home. Feeding infants inappropriately such as early introduction of complementary water or foods or opting for commercial formula rather than breastfeeding can render the baby vulnerable to waterborne illnesses.

The lack of proper hygiene practices, and clean water and decent sanitation – especially in the home, and often in health facilities themselves – contribute greatly to child mortality. Only a third of households have improved drinking water on their own premises – and only a quarter in rural areas. Cold winters and burning wood or charcoal inside the home may contribute to the high rates of pneumonia and other acute respiratory infections.

The slowing of progress on child mortality in Afghanistan in recent years is a matter of serious concern. There are many contributing factors to this stagnation, including poor public funding of the health sector, and the inability of the Government to ensure wider coverage and quality care. In addition, the wide disparities between rich and poor, and between geographic regions, have become more evident. Along with them are concerns about inequity in the allocation of resources. Not only does the Convention on the Rights of the Child require governments to allocate the maximum extent of their available resources to advance children's rights, but ensure that children belonging to the most disadvantaged groups are protected against adverse effects of economic policies, including the reduction of budgetary allocation to the social sectors.

Primary education: Children not only have the right to education but also to an education that addresses the basic aim of learning: to provide the child with life skills, to strengthen the child's capacity to enjoy the full range of human rights values. This requires attention to quality in education. The goal is to empower the child by developing the child's skills, learning and other capacities, human dignity, self-esteem and self-dignity. The aim of education is also to help children develop respect for the natural environment.

In line with human rights law, all Afghan children are entitled to free and compulsory primary education. However, issues of access, acceptability and equal opportunity continue to deny about 3.5 million school-age children, around 75 per cent of them girls, their right to education. Social norms and insufficient facilities keep girls and children with disabilities within the home. The economic and social benefits of enrolling girls in school are significant. Studies indicate that infant mortality drops between 5 and 10 per cent for every additional year a girl spends at school. Thus, expanding girls' education could bring concrete benefits in reducing infant and child mortality⁷. Increases in secondary schooling for girls have also led to a decrease in domestic violence.

Even children whose families are willing to stand up against cultural norms may find themselves excluded from education by the non-availability or inaccessibility of schools. Poverty and conflict play a major part in denying children their right to education.

The physical absence of schools remains a significant infrastructural problem. More schools are needed every year to accommodate the ever-growing numbers of children in a society where the birth rate remains among the highest in the world. Yet the pace of building schools in Afghanistan is not keeping up with demand. The Ministry of Education estimates that it will take at least 13 years to meet the school infrastructure demand at the current optimistic projection of being able to construct 500 new schools per year.⁸ Even those schools that are built often lack suitable facilities – including protective boundary walls, the absence of which reduces the likelihood of girls' participation, given families' concerns about on-going insecurity. The lack of water, sanitation and hygiene facilities in schools is a significant factor affecting the enrolment and attendance of girls and children with disabilities, and the health and hygiene of those attending such schools.

Schools are unevenly distributed, often established in urban and easy-to-reach areas, which means children from remote areas have to travel long distances in order to access education. It is generally true in all countries that the farther a child lives from school, the less likely they are to attend or remain in school – especially those with disabilities or those who are otherwise marginalized or excluded. Distance from school is particularly important in Afghanistan on two counts:

the on-going conflict means that security concerns are very likely to deter parents from allowing their children to travel far outside their own community. Moreover, the social norms that limit the mobility of girls prevent them from traveling long distances.

Children who have missed out on education – perhaps as a result of the conflict, or because they have had to start working – have little opportunity to re-enrol or to catch up. The school year is also not well aligned with seasonal challenges. Children are often unable to attend due to severe winters, or when they end up working in the fields during harvest time. There has also been, until very recently at least, a reluctance to consider alternative forms of education, especially community-based education, despite the fact that their value in the Afghan context has been clearly demonstrated. Insufficient investment in alternative schooling models for out-of-school children further marginalizes and discriminates against groups who are already vulnerable.

Children's right to education is all too often unmet even for those who make it to school: the level and quality of students' learning remains unsatisfactory, especially in the early grades. The lack of relevance of the education in a majority of schools also leads to waning demand. There is a

Issues of access, acceptability and equal opportunity continue to deny about 3.5 million school-age children, around 75 per cent of them girls, their right to education.

mismatch between the education curriculum in schools and the practical skills needed for the workforce, particularly in rural, agriculture-based areas. In such a context, it becomes all the more likely that families who are poor will prioritize and opt for the immediate contribution that a child's work can make to household income, over the economic benefit that schooling promises later on. The remote location and insecurity of certain areas means that even if schools have been established, recruiting teachers to work in them – especially qualified female teachers – is particularly difficult. Thus far, insufficient attention has been paid to remedying this problem. Given the prevailing norm in the country that girls in grade three and above are not to be taught by male teachers, the lack of qualified female teachers, especially in rural areas, is a major impediment to girls' education. In addition, teachers often do not have the requisite training to provide a high quality child-focused classroom experience in which children are protected from violence, respected and encouraged to participate.

Myriad deficiencies in the educational experience of Afghan children are evidence that the Government is not yet allocating the maximum resources possible to advance child rights.

Violence, abuse and exploitation: Children in Afghanistan can face a range of violations, exposing them to multiple risks of violence, abuse and exploitation, including: early and forced marriage; so-called honour killing⁹; domestic violence and corporal punishment, and neglect of children with disability¹⁰; increased risk of employment in hazardous sectors¹¹; increased risk of drug abuse¹²; sexual violence and abuse¹³; abduction, sale and trafficking¹⁴; torture and degrading treatment¹⁵; recruitment by parties to the conflict and increased risks of killing and maiming as a direct result of the conflict¹⁶; and victimization and stigmatization for survivors of violence and abuse.¹⁷

These present a complex, multi-layered situation that cannot be reduced to sweeping, generalized statements. Instead, it requires a nuanced, careful understanding. Some children may experience a continuum of violence, abuse and exploitation in their life: a girl, for example, may be married at 14 years of age, only to run away from a violent situation, and then be punished by the justice system responsible for her protection.

In Afghanistan, children are required to adhere to strict, conservative social norms while still developing into physical and psychological maturity. The reputation and honour of a family or clan – key determinants of economic and social standing – are realized by adherence to these strict social norms by family members, including children. Children are often obliged to take on adult responsibilities as a result of widespread failure to recognize children's entitlement to special protection associated with their physical and psychological maturity. This failure occurs at family, community and state levels, exposing children to more risks of violence, abuse and exploitation.

Immediate and underlying causes of violence or exploitation are often quite specific to each individual child's situation. For many, sudden onsets of economic shock to a family unit may be the immediate cause of an early marriage or a child being sent to work. At this level, decision-making in a household becomes a key determinant for the level of protection afforded to a child. Gross negligence, lack of oversight, biases in interpreting what is in the child's best interest, low capacity among immediate caregivers and duty-bearers: all of these can increase the risk of a child being exploited or abused. The caregiver may be the perpetrator or, as a direct result of their neglect, the child may be insufficiently protected from others who could harm them. Heightened levels of insecurity due to the ongoing conflict, and increase in criminal activities as a result of the law enforcement vacuum also put children across the country at extreme risk of violence.

For children who survive violence or exploitation, the lack of specialized services is a form of additional victimization, which exacerbates the harm done to them. Providing services to child survivors of violence in non-state-controlled areas is particularly challenging.

Often different forms of child exploitation or abuse also have common underlying causes. For example, children at risk of recruitment by armed forces and children at risk of child labour, including hazardous forms of labour, may be driven into dangerous occupations by their family's poverty. Both sets of children may also suffer from lack of ready access to schools or may come from families who are not prepared to accept their being educated.

There is no single, quick solution to the problem of violence, abuse and exploitation of children. Increasing the level of education and literacy in families, particularly among women, can improve the situation. Yet children of highly educated families may still face abuse ingrained in the social norms and the systemic neglect of state-supported services. Increasing livelihood opportunities and household income can reduce child labour but this may not prevent a range of other risks.

The risk of violence, abuse and exploitation is compounded by structural causes across family, community, national and international levels. Collective behaviour change is needed to allow communities to begin to challenge social norms that increase the risk of violence against children. Failing to recognize children as victims of abuse and exploitation and instead focusing on them as transgressors of social norms further stigmatizes young minds and bodies in need of protection and support. This has resulted in the deprioritization of a comprehensive child protection policy with a co-ordinating body across the relevant ministries. The legal and judicial framework is currently inadequate to measure up to the task of providing a protective environment for many children. Moreover, too often, families prefer local-level (or 'customary') justice systems, particularly for family, or 'private sphere' matters, where potential biases and discrimination against children continue unchecked.

Collective behaviour change is needed to allow communities to begin to challenge social norms that increase the risk of violence against children.



Afghanistan in context: foundation for child rights

AFGHANISTAN: FAST FACTS

Land Area: 652,090 Square Kilometres
Population: 27.5 million (2013)
Population Growth: 2% (2013)
Life Expectancy: 49 years (2011)
GDP per Capita: \$678 (2013)
GNI per Capita in PPP: \$1560 (2012)
Poverty Rate: 36.5% (2011/2012)
Average Economic Growth since 2002: 9%
Real Economic Growth in 2012: 11.8%
Food Insecurity: 7.6 million (2011/2012)
Human Development Index: 0.468, 169th of 187 countries rated (2014)

Sources: World Development Indicators, The World Bank, 2013; Poverty Status in Afghanistan. A Profile based on the National Risk and Vulnerability Assessment (NRVA), 2011/2012; The World Bank, 2012; Central Office of Statistics, Multidimensional Indicator Cluster Survey (MICS) 2010/11; Human Development Report 2014, UNDP, 2014.

Afghanistan over the past decade has recorded vast improvements in many areas. And yet, it remains at the bottom of the global Human Development Index. Deficits in key indicators related to children's and women's development – particularly those related to health and nutrition, education and protection – are exacerbated by social and economic pressures such as migration, unemployment, harmful practices and insecurity. Any deterioration in the already precarious social and economic well-being of the population is likely to undermine communities' resilience and reverse the recent development gains.

An overwhelming majority of Afghans are vulnerable on a number of fronts. They have a high rate of exposure to risk including natural hazards, conflict, lack of decent work, and population pressures. They lack key entitlements, such as basic education, health, nutrition as well as a social safety net or insurance. They are subject to social norms that lead to harmful practices and gender discrimination. And they suffer from weak governance in terms of a just and transparent legal framework, budget and capacity to deliver services.

Carefully considering all these risk factors – and determining their potential impact on children – is vital when engaging in sector-specific analysis or planning. The impact of risk factors is different for urban and rural, for poor and better off, for female and male. The ways in which services are designed and delivered should be related to inequitable outcomes influenced by risk factors.

The first part of this chapter will consider the macro-context which exposes families to risks, influencing their ability to cope when shocks produced by exposure to risks hit families.

Poverty and underemployment

Since the fall of the Taliban in 2001, Afghanistan has recorded exceptionally high economic growth rates, with gross domestic product (GDP) growing at an average of 9 per cent a year. This has led to a doubling of annual average per capita income, currently estimated to be around \$678. Despite the rapid economic growth, over one-third of the population lives below the poverty line and a significant number of Afghans hover just above it.¹⁸

The principal drivers of the past decade's economic growth have been foreign aid and military spending – since 2008, Afghanistan has been the world's largest aid recipient. According to the Organisation for Economic Co-operation and Development (OECD), Afghanistan again topped the list of official development assistance (ODA) recipients in 2012.¹⁹ The majority of ODA has been earmarked for the social sector (\$3.4 billion), followed by economic areas (\$1.3 billion) and then humanitarian (\$676 million).

Table 2 Top 10 ODA Receipts by Recipient USD Million, Net Disbursements

Country	2009	2010	2011	2012	4 year average	%
Afghanistan	6,235	6,426	6,711	6,725	6,524	5%
Congo, Dem. Rep.	2,357	3,543	5,522	2,859	3,570	3%
Ethiopia	3,819	3,525	3,563	3,621	3,632	3%
Vietnam	3,732	2,940	3,514	4,116	3,576	3%
Pakistan	2,769	3,013	3,509	2,019	2,828	2%
India	2,500	2,806	3,220	1,668	2,549	2%
Tanzania	2,933	2,958	2,445	2,832	2,792	2%
West Bank & Gaza Strip	2,817	2,519	2,444	2,001	2,445	1%
Iraq	2,791	2,192	1,904	1,301	2,047	1%
Mozambique	2,012	1,952	2,047	2,079	2,023	1%
Other recipients	95,012	99,234	101,560	133,039	107,211	77%
Total					139,197	100%

Source: OECD, Development Aid at a Glance, Statistics By Region: Asia 2014 Edition. 2014

World Bank research indicates that only a modest amount of aid currently reaches the poor because much of the aid has been directed not to reducing poverty but to improving security and governance. Inequity is still widespread; aid has not been well targeted and the direct benefits of aid flows, such as employment, appear to have accrued disproportionately to provinces with less poverty and to higher income households associated with aid-related industries, such as construction.

This does not augur well for the effective targeting of aid to the poorest sections of society. At the same time this does mean that the anticipated reduction in external aid is likely to have less impact on the livelihoods of the poor. The anticipated drawdown in aid means that annual economic growth is projected to shrink to 5 per cent by 2018. This is more likely to directly affect only a small segment of the population, mostly in the cities.²⁰

Poverty is less prevalent in urban areas (29 per cent) than in rural areas (38 per cent) where three-quarters of the population lives²¹ and where the majority depend on small-scale rain-fed agriculture for their livelihoods. According to the NRVA 2011/12, children under the age of 15 years old account for the largest proportion of the poor (53 per cent). The analysis suggests that households with larger number of children (i.e. a higher child ratio) are more vulnerable to poverty.

Drought or flooding can, and often does, lead to crop failure or reduced production, loosening the already tenuous grasp of rural populations on their well-being. According to the NRVA 2011/12, 30 per cent of Afghans are food insecure (consuming fewer than 2,100 kilo calories per day) and 8.5 per cent are severely food insecure (consuming less than 1,500 kilo calories per day).²³ A 2012 survey in drought-affected provinces showed that 34 per cent of households were food insecure, while a further 40 per cent were on the brink of food insecurity.²⁴

In the absence of any viable insurance (whether public or private) or government safety net, the recurring experience of seasonal crisis results in many families with no coping strategies. Even in urban areas, small shocks can tip families over the brink into poverty, or plunge those already below the poverty line into deeper crisis.

The labour market is heavily reliant on agriculture and the service sector; some 60 per cent of those employed work in low-productivity and subsistence agriculture.²⁵ Both sectors are extremely vulnerable: agriculture to drought, floods and other weather conditions, and the service sector to irregular and inadequate inflows of international aid. Most of the jobs available in the service sector, particularly those generated by the international community, are either casual or there is a mismatch between the skills of the labour force and what the market requires.

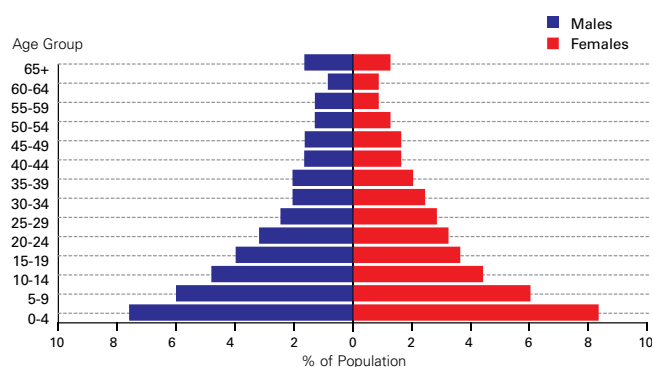
Given the lack of a comprehensive social protection programme, unemployment is not an option for families. Those with low levels of literacy and skills are, in practice, engaged in casual and irregular labour in the informal sector, which

accounts for 80-90 per cent of total economic activity.²⁶ So, while official unemployment is 7 per cent, 48 per cent are under-employed and 77 per cent of the labour force is in vulnerable employment.²⁷

Declining aid is likely to aggravate under-employment more than unemployment. Commerce and trade, especially in urban areas, is heavily dependent on the current war economy, which means it has limited sustainability.²⁸ Urban areas have strong informal economies (often shaped by the war economy) and have promoted 'the coping economics of survival'.²⁹ According to the Afghanistan Research and Evaluation Unit (AREU), the coping economy is characterized by a widespread struggle to survive in a high risk environment and is driven by a depleting asset base.³⁰ One of the main strategies of coping is to engage children in work that contributes to household income. The economic opportunities in Afghanistan over the next decade are likely to be limited largely to the commercial sector, the drug sector, the small-scale agricultural sector and remittances.

An emerging area of concern is the impact that the imminent economic downturn will have on the large number of adolescents transitioning from childhood to adulthood over the coming decade. Young people (those under the age of 25) account for an estimated 63 per cent of Afghanistan's population.³¹ More specifically, adolescents (those aged 10-19) account for roughly 30 per cent of the population (those aged 10-14 comprise 17 per cent of the population and those aged 15-19 account for nearly 13 per cent).

Figure 7 Afghanistan's Population Pyramid



Source: Central Office of Statistics. Afghanistan Statistical Yearbook 2012-2013. 2013

It is estimated that around 400,000 Afghan youth enter the labour force each year. However, the economic prospects for young people are bleak. The lack of job opportunities for up to one million young people, of whom only 5 per cent have a university education, has become one of Afghanistan's biggest challenges.³²

The situation is even more severe for young women, partly as a consequence of traditional attitudes to gender roles. Women's labour participation remains low, accounting for only 20 per cent of the workforce. Afghan women are locked in a poverty trap affecting their health, nutrition and education. Poor, uneducated and unhealthy women tend to raise poor,

uneducated children.³³ Role of fathers in childcare in a patriarchal society has at best been marginal often to the disadvantage of girls.

Afghanistan's current population structure means that it has one of the world's highest dependency ratios (the proportion of those under 15 or over 64 years relying on those of working age). The current scenario, with a relatively under-productive population suffering conditions of conflict, is an unhealthy recipe resulting in low productivity and poor economic development.

Natural hazards and conflict

Afghanistan faces a complex situation characterized by continuous humanitarian needs in the middle of an unresolved peace process. Conflict, natural hazards, chronic poverty and underdevelopment continue to threaten people's survival, livelihood and dignity in many ways. The prolonged displacement of around 600,000 people and the difficult process of reintegrating them into their former communities generate new demands for services, infrastructure and livelihood for both the displaced and many of the host communities. On the other hand, persistent insecurity hampers access to some of the affected population, mostly women and children. At the same time, recovery and reconstruction are required in parallel to humanitarian aid to address some of the social and economic disparities still prevalent in many of regions.

Conflict and natural hazards are the main sources of vulnerability for nearly all Afghans, having a profound impact on their human rights. The right to live in dignity, with an adequate standard of living and security are enshrined in many human rights conventions and declarations. In humanitarian settings (in the midst of conflict or following natural disasters), the condition of Afghans is expressed in the form of:

- lack of security;
- loss of social capital and breakdown of the social fabric;
- loss of livelihood;
- lack of shelter;
- lack of safe water and sanitation; and/or
- lack of essential health, nutrition and education services.³⁴

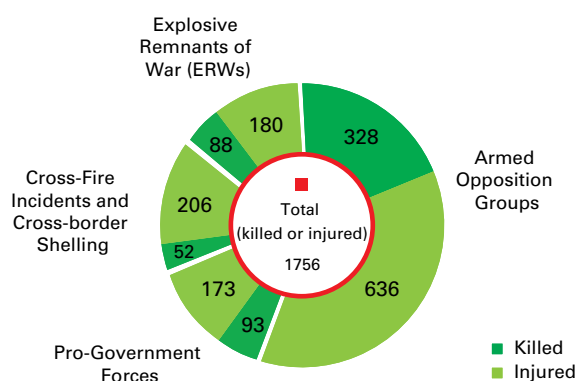
Conflict and frequent natural disasters continue to take a devastating toll on Afghanistan and are major impediments to the attainment of women's and children's rights. Conflict and hazards are interlinked and serve to magnify the extreme vulnerability of Afghans. The combination has severely undermined the resilience of communities to the extent that small-scale hazards or disasters (such as flash floods) tend to have a devastating impact on the affected populations, at least half of whom are usually children. In 2013, there were nearly 125,000 newly displaced IDPs due to the ongoing conflict, and approximately 235,000 people were affected by natural disasters.³⁵

Conflict

The ongoing armed conflict in Afghanistan continues to have

a direct impact on the safety and protection of children. The continuing insecurity is in part due to continued attacks by the Anti-Government Elements (AGE), and their expansion into previously stable areas that were controlled by counter-insurgency operations of the Afghan National Security Forces and the International Military Forces.³⁶ Between 2009 and 2012 there were 5,025 child casualties reported and verified.³⁷ Children continue to be killed or injured in conflict-related violence as victims of improvised explosive devices (IEDs), air strikes, rocket attacks, mines and unexploded ordnance accidents, and the psychological effects of conflict. The year 2013 was the worst for child casualties with 1,756 verified reports of killing and maiming. The 35 per cent rise is thought to be largely due to the increased use of non-precision weaponry and collateral damage and indiscriminate targeting of civilian populations. Figures for 2011 remained high, at 1,325 child casualties. The pattern was similar in 2012, with 1,304 deaths or injuries recorded as a direct result of the conflict.

Figure 8 Causes of Conflict Related Casualty Among Children in 2013



Source: UNAMA and OHCHR "Afghanistan Annual Report on Protection of Civilians in Armed Conflict: 2013. February 2014.

For the third consecutive year, the use of IEDs remained the main cause of child casualties, killing 172 and injuring 227. An overwhelming majority of civilians killed by explosive remnants of war and landmines are boys outside of the formal education system tending to livestock, collecting firewood, or those earning their livelihood through the collection and sale of scrap metal.

Boys in Afghanistan are recruited and used by armed forces and armed groups as instruments in the conflict. The Country Task Force on Monitoring and Reporting reported and documented more than 400 cases of recruitment and use of children by parties to the conflict between 2009 and 2012. The national policy states that 18 is the minimum age for enlistment in the Afghan National Security Forces (ANSF). However, insufficient age verification procedures, extremely low levels of birth registration, opportunities to manipulate age in national identity documents, and fast-tracked recruitment drives within the Afghan National Police have led to under-age recruitment. Armed opposition groups also recruit and use under-18 year olds, reportedly in various capacities which can include suicide attacks, transportation of weapons and explosive materials, manufacturing and planting of IEDs,

tea-making, domestic duties, and spying. These children are often doubly victimised as they are also detained on national security related charges. Between 2009 and 2012 more than 500 children were detained in Juvenile Rehabilitation Centres on such charges. The number of children previously and currently held in detention facilities overseen by the National Directorate of Security and the International Military Forces is unknown.

Continued attacks against schools and hospitals and their personnel violate the right of children to access quality education and health services – depriving children in Afghanistan from reaching their full potential and being prepared for a durable peace. Records from the Ministry of Education and the Monitoring and Reporting Mechanism on Children and Armed Conflict suggest that there have been approximately 1,500 attacks on schools between January 2009 and May 2013. These attacks include direct attacks, IEDs placed in education and health facilities, forced closures, and threats and intimidation of education and health personnel, and also of students and patients. In addition, issues around shrinking humanitarian space, such as increased AGE attacks on civilians, including both national and international aid workers, and the inability to access children is a further consequence of insecurity. The conflict further impacts access to social services through self-exclusion, particularly in the South Region, where some families choose not to use public services for fear of being perceived as sympathetic to the Government.

Internal displacement due to conflict and insecurity is a major concern because of its associated humanitarian needs. As of December 2013, some 631,353 individual IDPs were reported by UNHCR countrywide. Of these, 51 per cent (324,897) are girls and boys under the age of 18 years. Although the initial response is coordinated by UNHCR and the Ministry of Refugees and Repatriation (MoRR), there still remain large gaps in their access to basic social services.

Despite efforts by the Government to develop and implement policies to protect refugees and internally displaced children and families, they continue to experience problems in accessing birth registration, national identity documents, and skills appropriate placement in schools. Refugees and IDPs are also denied access to education, safe drinking water and sanitation on the basis of their ethnic background and are disproportionately involved in hazardous labour.³⁸

The conflict has had a profound impact on the psycho-social well-being of children in Afghanistan. The country's capacity to protect children and respond to their needs, including their psycho-social health, is severely lacking, and needs concentrated attention in the years to come.

Natural disasters

Three decades of war and conflict have negatively affected Afghanistan's natural environment. Already disaster prone, and subject to a wide range of sudden onset emergencies such as earthquakes, floods, flash floods, landslides and avalanches, environmental mismanagement and degradation have left the country prone to devastating drought and deser-

Figure 9 Seasonal Calendar of Natural Disasters in Afghanistan

Event	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Avalanches												
Landslides												
Extreme Winter												
Floods												
Extreme Summer												
Drought												
Earthquakes												

Source: UNICEF Afghanistan. Emergency Briefing Note. 2013.

tification. Afghanistan is one of the 20 most disaster prone countries in the world and ranks 5th and 17th respectively in terms of vulnerability to earthquakes and floods.³⁹ Natural hazards and conflict deplete and reduce access to natural resources, rendering essential lands and pastures unsafe, thus leaving out large sections of society who are unable to access their main source of livelihood. According to the World Risk Report, Afghanistan ranks fourth globally in terms of vulnerability, and weakest in terms of coping and adaptive capacities.⁴⁰ This means any small trigger or shock can easily become a disaster due to high vulnerability and low capacity.

The scale of a natural disaster is closely linked to a society's response capacity. In Afghanistan the ongoing conflict and limited attention to disaster risk management has weakened systems and structures for dealing with hazards. Given that natural disasters occur every year in varying degrees, the need for humanitarian action arises on a regular basis. This can create dependency among the affected communities and undermine their resilience and coping mechanisms. As elsewhere in the world, the poor tend to live in more marginal environments that are subject to greater risk. Women and children tend to be disproportionately affected. Dependent children can be adversely affected by some of the coping mechanisms adopted by their households.

Each year an average of more than 250,000 Afghans are directly affected by natural disasters. Most of these are predictable in the sense that they tend to occur in particular places at particular times of the year, which can be prevented and mitigated through increased risk reduction and full preparedness of the communities most likely to be affected.

Earthquakes, for example, are primarily restricted to the North and Northeast. Floods are prevalent primarily in the North and Southwest (although flash floods are on the increase across the Central Region). Extreme temperatures are a feature of the central mountainous belt as well as the Northeast (see Annex 6 for Risk Maps).

Some of the hazards such as earthquakes, floods, flash floods and harsh winter are most effectively addressed through early warning and emergency preparedness measures. Others,

such as drought, chronic flooding and avalanches, can only be effectively managed through disaster risk reduction and good planning. These measures can result in effective early response plans and large-scale development interventions, including infrastructure repair and riverbank reconstruction. In reality, however, development efforts have failed to yield significant results in these areas. Therefore, natural hazards continue to threaten people, rendering them dependant on life-saving assistance.⁴¹

Increased conflict, seasonal flooding and earthquakes are the main causes of the large and recurring humanitarian situation.⁴² Humanitarian needs are exacerbated by a high levels of poverty and under-development, leaving families and communities unable to absorb shocks caused by natural and man-made disasters.

Access and humanitarian response

Victims of humanitarian crisis in Afghanistan face severe problems getting access to assistance. People in most areas receive relief items directly through humanitarian agencies, or through intermediaries such as the Government. However, with less direct access, little verification and quality control of humanitarian assistance can be undertaken. Humanitarian agencies operate in a volatile environment and they regularly face attacks on their personnel, vehicles and assets. But many less spectacular attacks, including shootings and kidnappings, perpetrated by different AGEs or criminal elements, go unnoticed. There is increased realization among humanitarian agencies that community acceptance is the key to maintain continued access in conflict-affected parts of Afghanistan.

While there is nothing new about this insight, it is not always acted upon in reality. In Afghanistan, 'hardening' has been a primary response, the limits of which have now been reached.

While the armed conflict and threats of violence is a limiting factor for humanitarian agencies, there are other reasons as well that sometimes make humanitarian assistance in Afghanistan slow to arrive and reach affected populations during rapid onset of emergencies. Reasons for delays include prolonged verification of initial assessments, insufficient resources of humanitarian agencies, centralized processes of some agencies, and hard-to-reach locations. In very conser-

Increased conflict, seasonal flooding and earthquakes are main drivers of the large and recurring humanitarian situation.

vative parts of the country it is often difficult to reach women and girls. However, different approaches are used to make access to communities more effective, including the use of Afghan Red Crescent Society (ARCS) volunteers, and involving the Community Development Council (CDC) and shura leaders in the assessment and response processes.

Humanitarian funding for Afghanistan has been rising quickly over the last years, where the UN is the main channel of aid for donors. But the flow of resources directly to NGOs and the Red Cross/Red Crescent Movement has also increased dramatically. This increase reflects in part greater needs as well as a growing willingness to cover previously unmet needs.

Table 3 Humanitarian Assistance Channel of Delivery

	2006	2007	2008	2009	2010	2011
UN	175	387	1141	980	1317	1434
NGO	67	279	364	546	757	647
Others	133	176	110	49	82	82
Public sector	87	336	554	406	400	265
Red Cross	4	10	44	75	65	67

Source: Development Initiatives based on OECD DAC CRS (constant 2011 prices) and UN OCHA FTS data

Migration and urbanization

Migration

Migration, as a consequence of economic and security reasons, is not a new phenomenon for Afghans. High rates of poverty, limited economic opportunities and conflict often push families and children to migrate either within the country or abroad. The most popular destinations for economic migration are Iran, Pakistan and urban centres within Afghanistan. Many have also moved to Europe and North America. Migration from rural to urban areas tends to be 'unidirectional and permanent with male head of household or entire families moving'.⁴³ Migrants going abroad, particularly to Iran and Pakistan, tend to have a more fluid pattern, making several return trips to Afghanistan. Remittances from abroad play a vital role in the household economy. For 96 per cent of families with relatives in Iran, for example, remittances contribute to more than half their income, and for 37 per cent it is their only source of income.⁴⁴ There are no official statistics on children, adolescents and youth who migrate abroad without their families but the phenomenon is believed to involve a disproportionate numbers of boys. There has been a significant increase in the number of separated and unaccompanied children applying for asylum in Europe since 2007.⁴⁵ Many of these children do not have legal documents or family structures to support them in the destination countries. Without these documents, they are at heightened risk of exploi-

The population in urban areas is growing at more than five times the rural rate (23.5 per cent compared to 4.5 per cent), putting heavy pressure on social services and infrastructure such as schools and hospitals.

tation and abuse, both during migration and when they reach their destination without necessary documentation and support.

Urbanization

Afghanistan is rapidly urbanizing. Kabul was the fastest growing city in the Asia-Pacific region, apart from cities in China, between 1995 and 2005.⁴⁶ The population in urban areas is growing at more than five times the rural rate (23.5 per cent compared to 4.5 per cent), putting heavy pressure on social services and infrastructure such as schools and hospitals. Quantitative data indicate that urban areas are better off in terms of child well-being and access to basic services. However, these data tend only show averages, often concealing stark differences among different groups. Once in the city, families often have no choice but to settle in slums where they lack access to decent housing, water sources, sanitation, health care and education. Limited land availability has pushed people to settle in precarious places, such as the steep hillsides surrounding Kabul. These informal settlements are characterized by high exposure to natural hazards such as extreme winter weather, limited access to clean water and unhygienic environments, raising serious public health concerns.

Qualitative research by the AREU in three cities demonstrates the vulnerabilities that families in urban areas face, including loss of income and poverty, food insecurity, poor health and education, and social exclusion.⁴⁷ The study also revealed that respondents are greatly dependent on child labour for household income to buy food and essential items. While poverty does not automatically result in child labour, it is an influencing factor. Child labour can be severely detrimental to children's health, education and future livelihood prospects.

Social norms⁴⁸

The central driving force behind social norms in Afghanistan is the upholding of family honour and the standing of the family within the community. The norms

are centred on notions of honour and shame, which are governed by tribal codes and interpretations of Islam. These social norms are by no means uniform; there are distinct variations between ethnic groups, religious schools (such as reformist and ultraconservatives) and geographic locations (rural and urban) in terms of what constitutes socially acceptable behaviour.

There is, however, a basic commonality that dictates behaviour across Afghanistan. This is exemplified in the tenets of Pash-tunwali, under which: "behaviour is honourable or shameful when it is honourable or shameful in the eyes of other people. Consequently, the main rule of conduct is the question as to how one's behaviour is evaluated in the eyes of other people."⁴⁹ The idea that individual behaviour is a reflection of the honour and value of an entire extended family can have

“One way to prevent children from joining the police force is through birth registration.”

Wasil Mohmand,
Deputy Minister, Ministry of Labour,
Social Affairs, Martyrs & Disabled



FROM THE FIELD

When Suraiya was 6 years old, her older brother eloped with a neighbour's daughter. In an attempt to buy peace, Suraiya's parents gave her to the

neighbour's family. For four years, the family forced her to perform heavy household chores. She was physically abused, kicked and harmed with knives, sticks and iron rods. Suraiya's story is not unique.

Her parents were practising *baad*, the custom of trading young girls to settle debts or family disputes. Many young girls are physically and emotionally violated by those who receive them.

serious implications for the realization of rights, which are guaranteed at the individual level. Behaviours and actions that are in the 'best interest of the family', with regard to maintaining honour and limiting shame, can often be at odds with what is in the 'best interests of the child' from a rights perspective.

Prevailing social norms can in some ways create a very protective environment for children, women, and other groups. However, some of these norms can increase vulnerability. Strict sanctions can be meted out when actions deviate from acceptable behaviour, directly affecting individual rights.

Norms related to roles and functions

Men and women occupy different spheres in Afghanistan, though to some extent historic divisions are lessening. The *pardah* norms outline the acceptable roles and responsibilities for men and women. Generally speaking, for a man to be viewed as 'a man of honour' he must provide for his family and his family's action must be perceived as moral. These two aspects are his *nang* and *namus* (honour and reputation). While *pardah* norms put men in the public sphere, they can limit women's and girls' public presence, assigning them roles and responsibilities that confine them to the home. The World Bank notes: 'since women are the prime bearers of the family honour, their seclusion and chastity reflect the honour of the extended family, which controls (and limits) their relations with the outside world'.⁵⁰ This is, however, not consistent across Afghanistan. Women's public presence and freedoms can vary considerably depending on where they live and how well-off they are, among other variables. There is also some degree of dynamism in these norms. When and how progressive steps are taken within family dynamics needs further understanding.

Concerns over shame and the unequal power dynamics in the family can mean that many family-based disputes, such as domestic violence, go unchallenged and remain hidden in the home.⁵¹ Cases of domestic violence and abuse are preferred to be kept out of the public domain and dealt with internally by families or by a select group of elders from the community.

Regardless of differences in ethnicity, location and class, women in Afghanistan tend to be defined by their roles as wives and mothers: 'no matter how vital a woman's economic contribution [is] to her family's well-being, this remains of secondary importance to her position as wife and mother'.⁵² Women's identities are defined by their place in the family and community.⁵³ The role of 'mother' comprises a wide range of responsibilities: bearing children, nurturing them and teaching them how to behave, maintaining the household including cooking, cleaning, bringing water to the home and, in some instances, contributing to household income. As a wife her role includes listening to, obeying and respecting the husband and senior patriarchal and matriarchal members of the family. All these functions are vital for the preservation of Afghan society but more often than not these roles are unpaid and undervalued.

Traditionally, the father is the *nanawar*, or breadwinner, in the household and is therefore responsible for providing the material needs of the children in terms of education, food and clothing. Qualitative research indicates that the man's role as head of household and primary provider gives him more authority over decision-making and the right to discipline, sometimes using violent methods.⁵⁴

Gender boundaries are porous and to some extent dynamic. They can vary with the education of men and women, with economic opportunities, and with external contexts such as urbanization, exposure to 'modernity', and a range of other factors.

The gender socialization of boys and girls begins at an early age and follows the larger cultural context. Boys are expected to help their father in providing for the family, either by working in the fields or by engaging in paid labour. Daughters are expected to learn domestic duties. The skills of a young girl in performing domestic duties can have an impact on her eligibility for marriage. Given that honour is associated with a good marriage, the inability of a girl to perform housework at a satisfactory level, for instance, is justification enough for parents to beat their daughters.

The concept of *tarbia* (upbringing) is closely related to upholding a family's honour. Children who display good *tarbia* bring honour and respect to a family, while children characterized as *betarbia* (without *tarbia*) can be a source of shame. Notions of what constitutes a good upbringing are derived from Islamic teachings and *hadiths*.

Tarbia is delivered at different levels and by different people. In the home *tarbia* is directly recognized as being provided by parents. They are supported in this by the extended family such as uncles, aunts and grandparents but parents are ultimately responsible for the *tarbia* they deliver. Outside the family, religious leaders and elders are involved in delivering *tarbia* related to how children should interact with the wider community. At school, mullahs and teachers are responsible for delivering *tarbia*. A study conducted by the Peace Training and Research Organization (PTRO), commissioned by UNICEF, indicated that in communities across Afghanistan, parents felt that punishment involving physical and psychological violence was a justifiable method of instilling good *tarbia* in children. The use of physical punishment was, however, not uniformly accepted across or within communities.

Transition to adulthood

Ideas as to when a child becomes an adult differ both across, and within, provinces. The PTRO study showed that the views of respondents differed, not least over whether the transition from child to adult was a physical or a mental process – or both. Notwithstanding these differences, an overall pattern of childhood could be identified by the following phases:

- *Razi*: Between birth and two-and-a-half years, the child is breastfed and is cared for by the parents.
- *Ghaimomaiez*: Between two-and-a-half and five years are the core years of childhood, when a child is not expected to know right or wrong and is simply develo-

Cases of domestic violence and abuse are preferred to be kept out of the public domain.

ping and being looked after by parents.

- *Momaiez*: Between 5 and 10 years the child is expected to develop insights into right and wrong and begin to grow into a socially respectful role.
- *Mahareq*: Between 10 and 16 years the child develops into an adult (a point determined both physically and mentally)
- *Balogh/Baregh*: Adulthood, the start of which ranges from 13 to 18 years.

Clearly, this concept of childhood does not correspond to international standards related to the first 18 years of life. Childhood can end at puberty or just before puberty, particularly for Afghan girls. The fact that transition to adulthood can take place anywhere between the ages of 10 and 18 increases the vulnerability of children. The adolescent phase of development, defined by the UN as the age range of 10 to 19 years, is still a time of 'development immaturity'.⁵⁵ The social norm that places the transition to adulthood in Afghanistan so early means that children are often put into situations beyond their emotional, physical and psychological readiness. Exposing children to adult roles often places their development and survival at risk.

Marriage norms

The early transition to adulthood can mesh with other social and economic factors and result in early or forced marriage. There can be economic and cultural motivations for early marriage, as well as elements of honour and insecurity.

Early and forced child marriages can be seen as emerging from the expectation that 'family honour – and consequently family status – is maintained through the institution of marriage, with its role in controlling women's and men's sexuality'.⁵⁶ Late marriages are commonly viewed negatively and people in some communities are encouraged to marry their children as quickly as possible.⁵⁷ Marriage between two young people is used as a means of protecting family honour by restricting opportunities for pre-marital sex. Marriage is

even seen as a means of protecting family honour from the possibility of rape and its fallout. While acknowledging that it would be practically impossible to marry a girl who had been raped, AREU interviewees noted that it is easier to cover up the rape of a married woman.⁵⁸ As such, early marriage may be viewed as providing protection and 'a future' for a daughter given that social norms do not support her independence from the paternal or marital household.

Parents and others responsible for marriage decisions identified fear as a major factor driving early marriage between young people, even when they acknowledged that allowing a child to mature and choose for themselves would be a better approach.⁵⁹ They spoke specifically about the fear of what would happen to girls and boys in times of war and insecurity if they were not married: fear that another suitable proposal would not come or fear that the parents would die before they saw their children married and with children of their own.⁶⁰

Putting children in adult roles often places their development and survival at risk.

Poverty or economic slumps in a family can also be a factor in the marriage of young girls. High bride prices – *peshkash*, the act of selling daughters for cash in some provinces – can provide much needed income for poor families.⁶¹ In addition, families use *badal*, the exchange of daughters, to avoid paying bride price. There are also cases in which daughters are married off as compensation for a debt incurred. However, the links to poverty are by no means causal or exclusive; wealthy families may also marry their children off very young.

Social norms are not static and do change over time. While society does ultimately shape these roles, the Government also has an influence. There is ongoing debate now about the role of women in Afghan society, and as to whether or not the Government has the right to interfere in 'family affairs', for example by regulating or criminalizing domestic violence and other 'honour related' crimes. This has been exemplified in the recent parliamentary debates over the provisions of the Elimination of Violence Against Women (EVAW) law.

OTHER FORMS OF DISCRIMINATION

The degree of discrimination against certain groups of children is so systemic that it has serious effects on their survival and development and can initiate a lifelong downward spiral of deprivation and exclusion. Children who are born out of wedlock face extreme discrimination by society and the state. The Child Protection Action Network has recorded examples of children born either through rape or premarital sex being abandoned.

Children with disabilities also suffer from societal and government-based discrimination that greatly impedes their potential. Lack of access to appropriate health and education facilities, and weak understanding of disability rights, compound the challenges affecting the survival and development of children with disabilities. The existing structures cover only a fraction of the needs and are largely concentrated in a few urban centres. As a result, the vast majority of children with disabilities remain locked up at home, in the care of their mother, who may be completely overwhelmed by their needs.

Establishing an enabling environment

Social policy framework

Under the CRC, children are afforded the right to survival and development, including the right to an adequate standard of living. While the Government is not responsible for providing this right directly, its economic and social policies will directly impact upon a family's ability to provide appropriate living conditions for its children. The Afghan Government has adopted several policies that aim to improve the economic environment of the country as well as the social conditions of its citizens. The Afghanistan National Development Strategy 2008-13 (ANDS) is the country's Poverty Reduction Strategy that provides a coherent framework for both macroeconomic and social policy. Though ANDS mentions the Government's commitment to human rights, the document generally frames human rights in civil and political terms only.

The ANDS provides a broad vision of the future, but offers little by way of priorities for action. In order to more efficiently channel the Government's limited resources, 22 National Priority Programmes (NPPs), grouped within six clusters, were identified at the 2010 Kabul Conference. Of these, the most relevant to children are: Education for All; Women's Affairs; Capacity Building for Health, Skills Development and Labour; and Human Rights. Budget allocations are intended to be made in line with the priorities stated in the ANDS and the NPPs.

Aligned with the ANDS and the NPPs, the Government has enacted several policies to address cross-cutting issues that aim to influence economic and social progress. These include the National Action Plan for Women of Afghanistan, the Social Protection Strategy, the National Solidarity Programme, and the National Law for the Rights and Privileges of Persons with Disabilities. Child rights continue to be weakened by the application of different sources of law, including customary or Shari'a law, and inconsistent domestic legislation, much of which fails to meet international standards for the protection of children. The Committee on the Rights of the Child recommended a comprehensive Child Act that would supersede all laws not in conformity with the CRC and provide children with appropriate means of redress. The drafting process has begun, but even the passing of such an act will have limited results unless sufficient resources support the work of all relevant ministries and implementing agencies.

It will, however, not be enough to draft legislation and policy, based on international standards and assume that they will be implemented. The national discussion about children's role in society needs more time and airspace. The 'best interests of the child' has been seen as a culturally and socially subjective concept and awareness of international standards related to children's rights is low among the general public as well as within the Government. An informed discussion around the benefits of protecting the best interests of children in Afghanistan must drive efforts to improve legislation, policy and practice.

Social protection

Through its Social Protection Strategy, the Government, along with donors and UN agencies, has recognized that the protection of poor and vulnerable families is a key constituent for Afghanistan's development. The National Social Protection Strategy (2008-13) falls under the framework of the ANDS. It reinforces commitments made to promote social inclusion, reduce poverty and prevent those who are poor from falling into deeper poverty through sustainable income and transfer policies, pursued through pension reform as well as through programmes focused on extremely poor and vulnerable households.

The stated goals of the Strategy are to support economic growth, enhance security, ensure poverty reduction, and improve social inclusion and equality. It notes that, despite improvements since 2002, the country's social protection system "is still far from being sufficient to respond to: (i) the short-term requirements of the poor; (ii) the necessity to develop effective risk management and

prevention system, and (iii) the need to establish efficient mechanisms for risk mitigation and coping."⁶²

The social protection landscape in Afghanistan is characterized by private initiatives and interventions from the Government, NGOs and the international community. The resilience and resourcefulness of Afghan families, along with strong community networks and institutions, have provided protection in the face of dire social, economic and political developments. In recent times, particularly since the fall of the Taliban, these community-based responses have been augmented by more formal responses from NGOs and the international community. However, these have tended to be fragmented, *ad hoc* responses to crises. The Government and donors have recognized that there is a need to move from these disparate responses into a systems approach towards building a comprehensive national social protection system.

The Government has provided interventions covering several groups: martyrs' families, people with war-related disability, orphans and children enrolled in kindergartens, victims of natural disasters, pensioners, and the unemployed. This type of categorical targeting has led to significant leakages and greatly diminished the effectiveness of the social protection sector to respond to poverty and vulnerability. The Social Protection Strategy published in 2008 acknowledged that around 80 per cent of transfers in 2006 did not target the most vulnerable.

Social protection is generally accepted as an important component of poverty reduction strategies and is a fundamental right.⁶³ The impact that extreme poverty and social exclusion has on families is amplified in children given their age and gender-specific vulnerabilities. The risk of exclusion is further intensified for children in marginalized communities, and for those who suffer from inequities stemming from conflict, disability, and/or other factors. Targeting these vulnerabilities not only helps children, their families and com-

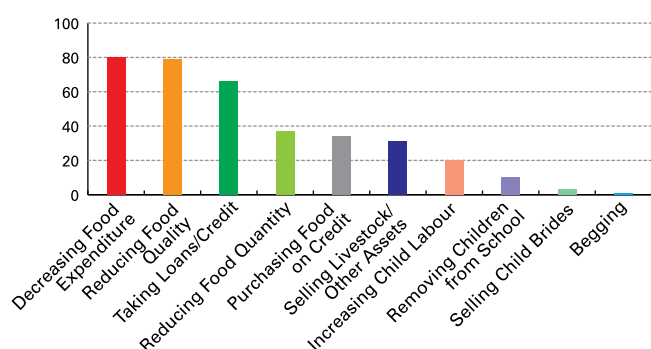
Around 80 per cent of transfers in 2006 did not target the most vulnerable.

munities but helps countries to attain equitable human and social development. The fundamental principles of a child- and gender-sensitive social protection system are that it:

- Addresses both social and economic vulnerabilities as well as age and gender-specific risks and vulnerabilities of children;
- Provides a comprehensive set of interventions based on assessed needs and context;
- Goes beyond risk management interventions and safety nets to integrate responses to social as well as shock-related vulnerabilities;
- Facilitates a multi-sector approach and co-ordination;
- Co-ordinates with appropriate supply-side investments to enhance availability and quality of services;
- Frames social protection strategies within a broader set of social and economic policies that promote human development and growth; and
- Helps children and women to claim their rights, and facilitates their participation in decision-making.⁶⁴

Families can be forced by the lack of safety nets, labour opportunities, low incomes, seasonality, high levels of poverty and vulnerability to poverty to adopt negative coping mechanisms in order to survive. According to the NRVA 2011/12, households employ a number of strategies to cope with shocks (see figure 10).

Figure 10 Household Coping Strategies



Source: NRVA 2011/2012

Coping mechanisms can have serious consequences for children: reducing the number and quality of meals impacts on nutrition and the need to repay debt can lead to abuse, violence and exploitation issues such as early or forced marriage and child labour. Removing children from school so that they can work is another mechanism commonly used. It is estimated that approximately 30 per cent of children engage in child labour. The incidence of child labour is higher in rural areas where children are involved mainly in pastoral and agricultural activities. In urban areas, children, especially boys, are often involved in brick kilns, carpet-weaving factories, begging and other activities.

Fiscal policy and the aid environment

The Constitution of Afghanistan affirms that social services, particularly health and education, are provided free to all Afghan citizens. However, given the large-scale need for services and the low, but growing, revenue means that Afgha-

nistan has to rely on external support for much of its public spending. This means that Afghanistan operates with two budgets. The 'core budget' is government-administered and contains both operating and development budgets. The 'external budget', meanwhile, is donor-administered and has relatively lesser government control.⁶⁵ In 2010-11, the total core budget was \$3.3 billion and the external budget was \$13.8 billion. External aid accounts for 91 per cent of the core budget. The continuation of external funding will be critical for maintaining and expanding the level of social service delivery for children and women, but there is a clear need to increase domestic funding for basic services. External funding can be unpredictable, with unfulfilled pledges or delays in transfers and it relies on donor countries' priorities which can shift or end suddenly.

At the 2010 Kabul Conference, it was agreed that development partners should commit 50 per cent of development aid to on-budget support (through the Treasury or through the Multi-Donor Trust Fund) and align their funds with the National Priority Programmes. There are, however, reservations among donors about contributing more to the Government budget given concerns over corruption, weak control of public expenditure and low execution rates. All of these have adverse consequences for establishing systems for the provision of basic social services and protective mechanisms.

According to the World Bank: "core development budget expenditures equivalent to 9 per cent of GDP remain undischarged each year".⁶⁶ Execution rates of ministries' development budget remained troublingly low in 2012, when "almost half of the ministries executed less than half of their development budgets".⁶⁷ At 34 per cent, the Ministry of Education had the lowest execution rate of its development budget. This is of particular concern given that the Medium-term Budget Framework states that those ministries with a low capacity to execute development funds would receive smaller budget allocations in the future.

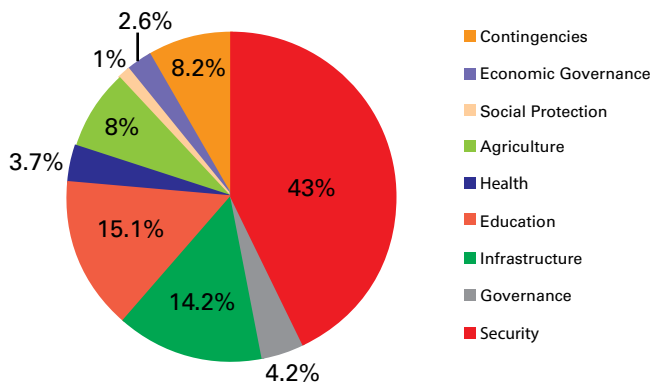
The overall low execution rate of the Government in spending its development budget is largely attributed to:

- Capacity constraints in line ministries;
- Lack of security in rural and remote areas of the country;
- Delays in procurement;
- Contractors in conflict with ministries;
- Improper follow-up with donor procedures; and
- Delays in signing grant agreements with donors⁶⁸.

Nevertheless, the Government appears to be on track to meet the World Bank target budget execution rate of 55 per cent for 2012-13. Moving forward, there will be more emphasis on delivering aid as direct budget support for the Government. Therefore strengthening the systems and capacities of ministries to spend their budgets effectively will be critical.

Reforms to public sector pay and grading, higher pension benefits, the increase in security personnel, the hiring of 10,000 new teachers per year to expand the provision of education to deprived areas: all of these have contributed to an ever-increasing operating budget. This has reduced the country's fiscal sustainability, as revenue collection – particularly from customs – has not kept pace with expanding expenditure.

Figure 11 Total Budget Allocation (Development and Operational) by Sector 2013



Source: Directorate-General Budget, Ministry of Finance, Citizen's Budget 2013

The total budget allocated for development projects has been steadily increasing over the past few years: core development expenditures 'increased by almost 500 per cent between 2002/03 and 2007/08' according to the World Bank.⁶⁹ At the Tokyo Conference of July 2012, \$16 billion was pledged through 2015 and beyond. However, each donor country set clear conditions for further support that included progress on protection of women's rights, stronger anti-corruption measures and implementation of fair election processes.

There are also concerns about the flow of funds from the central government to the provinces. In Afghanistan, the national budget flows from central line ministries to respective departments in the provinces and there are no block grants to the provincial governments. Development aid earmarked by the central government or channelled directly by donors seldom reflects provinces' needs or the size of their populations. Instead, it depends on other factors including the priority accorded based on criteria that are not necessarily objective and depend on donor interests and negotiations between provinces and ministries.

In the absence of provincial development budgets, many provinces in the past depended on funding from Provincial Reconstruction Teams (PRTs), which were under international military control. Studies have indicated that the way in which aid was delivered has sometimes contributed to instability through reinforcing uneven and oppressive power relationships, favouring or being perceived to favour one community or individual over others, and providing valuable 'ammunition' for actors to fight over.⁷⁰ The blurred line between needs-based assistance and the war effort has also challenged the ability of non-governmental organizations to maintain neutrality and independence, and to operate in areas outside the control of coalition and government forces.⁷¹

After the 'Transition' was initiated, however, major donors have shifted their funding away from PRTs, which are now closing, to on-budget support. As of March 2014, only 3 out of 32 PRTs were still operational, however, the Government cannot establish an equitable budget allocation to provinces and timely budget transfers, service delivery at the provincial

level may well deteriorate significantly. Alarming levels of deficits further accentuate the already precarious development funding to provinces and essential basic social services.

Increased funds to the social sectors can help achieve objectives for children but there is a need to ensure that the relevant mechanisms have sufficient absorptive capacity to manage the extra money. More money is not always the answer; advocating for additional funds to be allocated to an under-performing sector or institution will not automatically improve outcomes for children. As fiscal space contracts, ensuring that the funds allocated are efficiently executed will be all the more vital.

Legal and judicial environment

Afghanistan ratified the CRC, which requires the State Party to adopt measures to bring its national legislation in line with CRC provisions. Since the ratification of the CRC and its optional protocols 1 and 2, the Government has taken a number of initiatives to strengthen the protection of children's rights. In the last six years, laws with specific provisions for children have been reformed and adopted.

The legal framework for children's rights in Afghanistan faces a number of challenges. Afghanistan's report to the Committee on the Rights of the Child and the concluding observations of the Committee highlighted a number of structural problems. These include ambiguous and sometimes contradictory laws, a lack of awareness and implementation of existing legislation, and the absence of a coherent legal agenda for children's rights at the national level.

Afghanistan's legal framework contains inherent challenges and opportunities for the equal protection of girls, boys and women. Not only are there issues in reconciling diverse and seemingly competing legal sources into codified laws offering equal and comprehensive protection, there are also major challenges to implementing that protection. These challenges are exacerbated by the coexistence of parallel state and customary justice systems. The Afghan state legal system draws on Shari'a law, customary practices and secular law (including international conventions) in founding its laws. The CRC Committee in its concluding observations noted that different sources of law continue to have an adverse effect upon children's rights.

Shari'a law is not a barrier to women's and children's rights: it has several aspects that promote these rights and even advocate for the empowerment of women. The Constitution prohibits sex-based discrimination of girls and women and the Government has embraced a range of policies that make gender equality a key goal.

Non-state systems

Afghanistan, due to instability, changing regimes and the limited reach of the state, has had a long tradition of local governance. The rules governing local interactions were

drawn from secular law, interpretations of Islam and customary laws. Customary laws, a compilation of tribal codes and customs handed down orally and often vested in councils of elders, have provided a critical source of guidance in dispute resolution and communal reconciliation. Ministry of Justice (MoJ) estimates show that around 90 per cent of Afghans use non-state legal systems due to lack of “trust and confidence” and the “physical absence and low capacity” of state legal institutions.⁷² Distance, cost and illiteracy, coupled with prevailing social norms and perceptions of abuse and corruption, have also contributed to this distrust.

Non-state legal systems deal with all manner of issues – land and water, minor and major crimes, restitution of criminal acts and civil disputes – using a combination of local customs and Shari’a law. These systems facilitate access to justice for the poor and the illiterate. They have either no or low costs and do not involve transportation or paperwork but they discriminate on the basis of gender and age, severely limiting equitable access.

Women and children face numerous challenges in the customary justice system. Women face significant access issues: women’s testimony is considered to hold less weight than men’s, and men often represent women in court. Children are nearly invisible, with the majority of complaints brought to the customary courts by parents. This has grave consequences for their ability to seek and receive protection from physical, sexual or psychological harm, abuse, neglect and family violence. Children’s and women’s inability to represent their cases on their own behalf means that many domestic abuses of children and women go under-reported and unpunished. Customary rulings can be in conflict with national and international law as well as with Shari’a. An example is the practice of *baad*, which involves trading a girl as settlement of a dispute.

Customary laws and practices, moreover, include and perpetuate violence against women and girls. And, while both the formal legal system and the Constitution offer protection to women and girls, entrenched customary laws and practices have reigned over Afghanistan for much longer than the Constitution.

State system

Rebuilding the state apparatus has been a major focus of international assistance in Afghanistan. The state justice

sector does not reach many parts of the country and is not fully operational even in areas where it is present. Both state and non-state systems function in parallel, with limited links between them. There have, however, been instances of referrals between the two. The MoJ praises customary laws as ‘flexible and adaptable’ while acknowledging that customary practices can violate human rights. Tradition is not static and customary laws, in both interpretation and practice, are shaped by society as a whole and can thus change over time. There have in some cases, for instance, been changes in the practice of *poar* (blood money) that have seen disputes resolved by an exchange of livestock rather than of girls, as traditionally done.

While the Government has ratified many international conventions and protocols, these have not been fully included in the legal system, which affects their acceptability, implementation and enforcement. Although several laws with specific provisions for children have been adopted, the Government of Afghanistan does not consider the CRC a legally binding instrument and it has not yet been incorporated into the domestic legal system.

Afghanistan ratified the International Labour Organization (ILO) Conventions 182 on the Elimination of the Worst Forms of Child Labour in 2010. Article 49 of the country’s constitution also prohibits child labour and forced labour. While labour laws lay down a few provisions for prevention of child labour these are more focused on the formal sector, whereas a majority of children are engaged in informal work. Furthermore, while the Afghan Labour Code sets a minimum age for certain categories of work,⁷³ these do not adhere to the international standards set by ILO. Currently there is no policy or programmatic intervention in place through which the Government works towards the progressive elimination of child labour, and to meet its international obligation to eliminate the worst forms of child labour.

The different legal systems further complicate the issue of early and child marriage. The CRC is clear that anyone under 18 years is a child, while Shari’a sets no age limit on marriage. The Afghan Civil Code, meanwhile, states that males of 18 years and females of 16 years can marry. Marriage for girls aged 15 years is permissible with the father’s consent. The Shiite Personal Status law recognizes marriages for boys and girls ‘at puberty’ but it also refers to marriage as permissible ‘prior to the mentioned ages’ by a guardian

BIRTH REGISTRATION

Birth registration is essential to securing children’s rights, but 63 per cent of births remain unregistered. An efficient system for birth registration will not only prevent under-age recruitment but will also play an important role in protecting children from early marriage, child labour and criminal prosecution as an adult. In addition, there are serious concerns regarding the process of issuance of national identity documents and the possibilities that exist for falsification of age, especially at district level, and the use of inappropriate age verification procedures in Afghanistan. This is especially true with regards to the recruitment and use of under-18 years in the Afghan National Security Forces and in judicial proceedings.

GENDER SENSITIVE SOCIAL SERVICE SYSTEMS

Gender sensitive social service systems ensure that girls, women, boys and men have equal access to social services thus furthering equal life opportunities. Social services that are gender sensitive imply that the design of services and service providers take into consideration the different needs of girls, boys, women and men. They recognize the impact of those needs on outcomes and these are incorporated into decision-making and actions. Social services are truly gender sensitive when the socially defined roles between girls, women, boys and men are acknowledged and taken into consideration. In Afghanistan, gender issues have been reflected in numerous policies and strategies, but the gap between what is on paper and what gets implemented still remains. Social norms in Afghanistan dictate that girls over the age of nine years and women cannot be treated or taught by males. Therefore having an adequate number of female service providers is critical for having gender sensitive social services.

before the court.⁷⁴ This provision removes the power of the court to rule against early marriage, rendering the law ineffective. Child marriage is widely prevalent in Afghanistan, but there are no known cases where parents have been prosecuted for marrying off their under-age daughters. There have been positive reforms in the field of juvenile justice. The Juvenile Code of 2005⁷⁵ emphasized children's right to proper care, guidance, protection and the opportunity for social reintegration because they lack the moral, cognitive, physical and emotional maturity of adults. As such, it increased the age of criminal responsibility from 7 to 12 years, and laid out eight alternatives to detention, including performing community services and confinement to home. However, while it was developed to protect the interests of children, the code conspicuously fails to redress the situation of children who are victims of sexual abuse, exploitation or forced marriage.

The law as presently implemented lacks measures to protect victims of crimes, and children are particularly vulnerable to being targeted with charges of 'moral offences' to enforce social control. The prosecution of these children goes against international standards of juvenile justice as well as the rights guaranteed in the Afghan Juvenile Code. Presently no consideration is given to the circumstances of the offence committed. With the inability of the child to give consent, or address the abuse of children by adults, the juvenile justice system is not used for punitive nor rehabilitative purposes. Although the Juvenile Code of 2005 states that the situation and circumstances of a juvenile who is accused of an offence should be taken into account, the reality is that for 'offences' that challenge social norms this is rarely the case. A child victim of rape, for instance, may very likely be accused of adultery. The failure to develop and implement appropriate legislation and policies to protect child victims of abuse and exploitation is resulting in the systematic re-victimization of children in the justice system.

Governance and co-ordination

The responsibility for upholding children's rights is divided between several ministries. The Ministry of Labour, Social Affairs, Martyrs and the Disabled (MoLSAMD) is responsible for many child rights related areas, such as child labour, birth registration and social protection. The Afghanistan Inde-

pendent Human Rights Commission (AIHRC) is responsible for monitoring, promoting and protecting human rights, investigating and verifying cases of human rights violations and taking measures for the improvement and promotion of the human rights situation in the country. The Child Protection Action Network (CPAN) reports on abuses and violations of child rights to the MoLSAMD, and supports some of its activities. Both have an extensive network of offices at the local level.

Projects and measures aimed at protecting and promoting children's rights (and access to those rights) have been pursued by other organizations and ministries, including the Ministry of Education, Ministry of Public Health, the Ministry of Justice, and a number of local and international NGOs. These have largely been sector-specific, though there have been a number of co-ordinating initiatives, including the National Plan of Action (targeting child trafficking) and the National Strategy for Children at Risk. However, diffusing responsibilities throughout the Government and the NGO sector poses significant challenges. The planned establishment of a Children's Secretariat, which will be responsible for co-ordinating between ministries and other organizations and promoting a coherent child protection agenda, should go some way towards improving this situation.

Ensuring that women's and children's rights are met and protected is an indispensable part of Afghanistan's future. It will increase the country's capacity to cope with the many challenges that currently afflict it, from poverty and under-employment through natural disasters and conflict to migration and urbanization. The World Bank notes that "low human capital reduces the rate of return on physical capital, diminishes the profitability of investments, the adoption of new technologies as well as the structural transformation of the economy." It is therefore vital that the human development progress seen over the last decade is sustained, and that investments in health and nutrition, education, water and sanitation, and child protection – the sectors on which this report now concentrates in detail – remain at the heart of Afghanistan's development strategy.



Child Protection

Status and trends

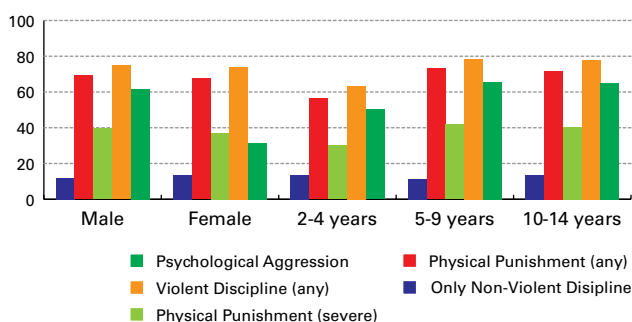
Violence, abuse and exploitation affecting children in Afghanistan take many forms, both covert and overt. Efforts to prevent and respond to such incidents have been inadequate and insufficiently co-ordinated. The social climate in many ways perpetuates beliefs and practices that can be harmful. Violence, abuse and exploitation of children are pervasive. It occurs at all levels of society: in the family, in the community and in institutional settings. Legal frameworks and mechanisms for justice can also perpetuate violence.

Family level

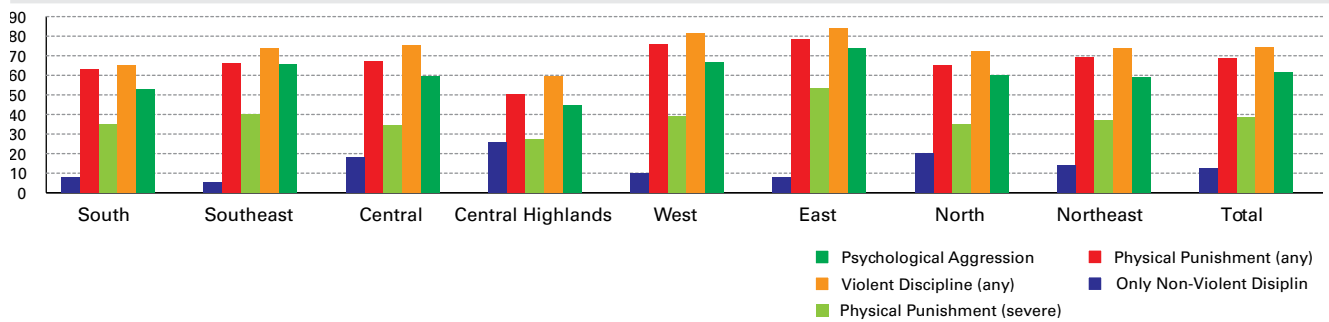
The family is the first layer of protection for children. Yet domestic violence against children is extremely common in Afghanistan. An AREU study found some form of domestic violence in all the 61 homes it surveyed.⁷⁶ Domestic violence in the form of violent punishment is more often used to instil fear. Parents and caregivers feel that children are exposed to greater risks of 'immoral' behaviours. Therefore, children who are fearful of their caregivers are less likely to transgress strict social norms.⁷⁷ Connected to and perhaps intensifying this worry is the belief that children who show poor *tarbia* or

akhlaq reflect dishonour on the family. The common belief is that if a child is being beaten they must have done something to deserve it. This sets a dangerous precedent and the presumption of a child's 'guilt' tends to extend all the way to the judiciary, affecting children who come into contact with the law.

Figure 12 Methods of Disciplining Children by Sex and Age



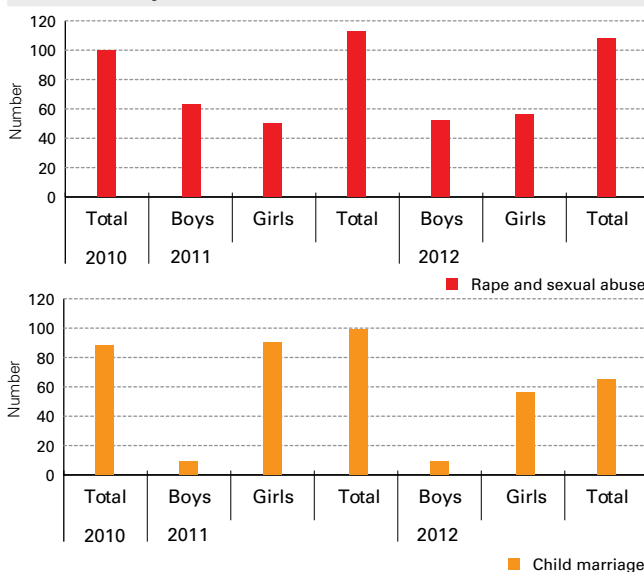
Source: MICS 2010/11

Figure 13 Methods of Disciplining Children (ages 2-14 years) by Region

Source: MICS 2010/11

The AIHRC and AREU held public discussions about violence in the home which suggested that such violence had decreased in the past decade. This change was attributed to migration, both internal and external, to people's exposure to alternative means of punishing or expressing anger, to positive messages through the media, to improvements in living conditions, and to women's awareness about their rights.⁷⁸

Sexual abuse of children and violence towards young brides is a major child rights concern across the country. CPAN reported 108 cases of rape and sexual abuse against children in 2012, noting that in 'most cases' the perpetrator was a relative or a person known to the child. Of these cases, 52 per cent involved girls and 48 per cent boys.⁷⁹

Figure 14 Cases of Sexual Violence Against Children Reported to CPAN

Source: CPAN, 2012

Early and forced marriages of children are also a gateway to violence, abuse and exploitation of children. Survey data from 2010-11 found that 46% of women aged 15 to 49 years were first married or in union at the exact age of 18 and that 15% of the same group were married or in union at the exact age of 15.⁸⁰ When a girl marries before she is physically and psychologically mature, there are numerous potential risks to her survival and development. Contraception is uncommon among married couples in Afghanistan and a young bride is expected to become pregnant soon after marriage. Childbirth and its associated complications are the leading cause of death in girls aged 15 to 19 years in developing countries and can cause severe and permanent damage to young bodies. The survey also revealed that 15 per cent of women aged 15-49 years were married before they turned 15, while 46 per cent married before their 18th birthday.

Girls married young tend to experience several rights violations, they are unlikely to be able to give informed consent, they are less likely to go to school, they may not enjoy access to reproductive and sexual health care, and they face restrictions of movement and association. Marriage for young girls can be 'tantamount to bonded labour or enslavement', subjecting them to repeated sexual abuse and economic exploitation.⁸¹ As described earlier, many families consider child or early marriage as a means of protecting their children.

Yet, there are opportunities for change. Education of girls has proven to be a strong deterrent to early marriage. Girls without education are more than three times more likely to be married before the age of 18 than those with secondary or higher education.⁸²

A particularly heinous manifestation of violence against children in Afghanistan is so-called 'honour killing,' punishment



/ FROM THE FIELD

Farzana (name changed) was just 10 when she got engaged to a wealthy 50 year old farmer who was already married with six children. The man gave her father more than \$9,000 for

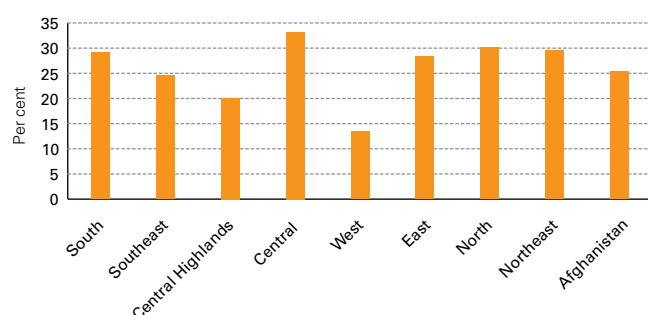
her hand in marriage. The shy school girl was devastated.

"I was crying very hard and telling my parents that I don't want to go through with this." Even Farzana's little brothers were shocked.

for transgression of social norms related to female chastity that 'dishonours' the family. AIHRC identified a range of legal, political, cultural, social, and economic factors contributing to these extreme forms of violence against women and girls. Prime among them was a lack of commitment from law enforcement agencies.⁸³ 'Honour killing' requires, at the very least, a zero-tolerance approach under the law.

Child labour is also a systemic, countrywide problem. Almost a quarter of all children are engaged in some kind of exploitative labour, 27 per cent of children aged 5 to 11 years and 22 per cent aged 12 to 14 years.⁸⁴ More boys than girls are involved (28 per cent and 23 per cent respectively), and almost twice as many children in rural areas (28 per cent) as in urban locations (15 per cent) are engaged in child labour.

Figure 15 Percentage of Child Labour (ages 5-14 years) in Afghanistan by Region



Source: MICS 2010/11

Child labour is particularly common in hazardous sectors in Afghanistan: brick kilns, carpet weaving, metal work, mines, street work and recruitment in armed groups/forces.⁸⁵ Child labourers are more likely to be at risk of physical and sexual violence due to their exposure to adults outside a protective family circle. Poverty is not necessarily a direct cause of child labour⁸⁶ and caregivers' decision-making often determines whether a child will do hazardous work. This suggests that families might be persuaded to consider other legal work options.

Drug use is on the increase in Afghanistan.⁸⁷ The drugs commonly used by children aged 10-15 years were cannabis, opium and heroin; opium, tranquillizers and cannabis are commonly used by children under 10 years.⁸⁸ Children of parents who regularly use drugs are more likely to be exposed. Narcotics are sometimes used as general painkillers to treat children's headaches, fevers and stomach problems. Stories of parents sedating children while they weave carpets or work in the field are also not uncommon. Involving children in cultivating or smuggling illicit narcotics condemns them to serious physical and criminal risks. The age of criminal culpability in Afghanistan is 13 years and 7 per cent of children in juvenile rehabilitation centres in 2010 were detained on drug-related charges.⁸⁹

Opportunities for drug treatment are rare for Afghans, despite the relatively large percentage of the population struggling with drug addiction. For women and girls the problem is

compounded by social norms that make it difficult for them to access treatments, requiring 90 days away from home.⁹⁰

Community level

There is very limited research available on violence in educational settings in Afghanistan. However, despite being prohibited under the Education Law, corporal punishment in schools is common. The Committee on the Rights of the Child noted particular concern over the 'discipline/school guards committee', comprising both teachers and students, which have 'full permission to use physical punishment on school children'.⁹¹ Abuse of children in *madrassas* is a sensitive subject with little conclusive research. The lack of monitoring by independent bodies is a concern, as is the absence of formal student complaint and remedy mechanisms.⁹²

The pull towards overseas migration for adolescents in Afghanistan can be very strong. Irregular migrants are at particular risk as they travel and work without legal documents or family protection. 'Domestic' trafficking in Afghanistan is more prevalent than transnational trafficking, though the latter is not uncommon. The majority of trafficking victims are children, and increasing numbers of boys and girls are reported to have been subjected to forced labour in carpet-making factories and domestic servitude, as well as to commercial sexual exploitation, forced begging and drug smuggling.⁹³

While there is very little information or systematic research, there is reason to believe that both boys and girls are 'sold' or 'released' by their families into situations where they are likely to be sexually abused or subjected to commercial sexual exploitation. While this kind of exploitation can take many forms, one frequently reported is the practice of *bachabazi*, a sexually and psychologically exploitative relationship between pubescent boys and influential men in the community.

Children working in the streets are more likely to be exposed to intravenous drug users, the group most at risk of HIV infection. The HIV discussion in Afghanistan has been muted. There is little public awareness of the virus, including how it is transmitted, perhaps due to taboos around discussing multiple sexual partners.⁹⁴ A World Bank briefing of July 2012 notes 1,250 HIV positive cases being reported.⁹⁵

Institutional level

An assessment of government and private orphanages in six provinces in Afghanistan conducted by Children in Crisis found worrying trends suggestive of gross negligence in oversight and regulation. Among the public and private orphanages surveyed, only 12 per cent of children were without both parents.⁹⁶ The poor staff-to-child ratio does not allow for consistent oversight, monitoring and supervision, particularly at night, potentially exposing children to greater risk than if they were to remain within the family setting. Despite numerous anecdotal reports of violence and abuse, there has been no systematic effort to monitor, record and prevent such incidents.

More than 600 women and girls have suffered detention for so-called 'moral crimes'. These crimes are prima-

*“We had a lot of problems –
we were so poor, we had nothing.
If we didn’t have these problems,
we wouldn’t have agreed to this marriage,”*
says Farzana’s father.



// FROM THE FIELD

Farzana says she pleaded with her father to cancel the wedding, promising to eat only bread so she wouldn’t be a financial

burden on the family. But her father says he had no choice. Earning less than \$30 a month as a casual labourer, the money offered for Farzana was too much to refuse. “We had a lot of

problems – we were so poor, we had nothing. If we didn’t have these problems, we wouldn’t have agreed to this marriage,” says the father.

rily categorized as 'running away' (leaving home without permission), *zina* (extramarital sex) or 'attempts to commit *zina*'. As 'running away' is not a crime, girls are often charged with one of the other two offences; weak or non-existent criminal investigation and judicial procedures mean their convictions are often subjective.⁹⁷ Detaining girls for 'moral crimes' is a gross violation of child rights. It also promotes the idea that transgressions of cultural norms are 'crimes' that require violence and abuse as legitimate forms of social control. Many girls face retribution by their families when they are released from detention, or are unable to return home at all.⁹⁸

Children detained on national security charges face multiple risks. They are more likely to be tortured or ill-treated, less likely to see legal counsel and may also be at risk on release of retaliatory harm or re-enrolment in armed groups. Of the 105 children interviewed for a 2013 report, 80 had experienced 'torture or ill-treatment'.⁹⁹ There have, as yet, been no prosecutions of Afghan National Police officers for using torture,¹⁰⁰ suggesting a culture of impunity and lack of political will to protect children. In any judicial proceedings against such children, they should be treated first as victims in need of rehabilitation and reintegration as specified under Article 39 of the CRC. Ending and preventing child recruitment and use in armed groups should be included in any peace and reconciliation talks with parties to the conflict.

Key strategies

There is inadequate attention afforded to child protection in the national planning strategies of Afghanistan. And a consistent, holistic and multi-sectoral approach to child protection is lacking. The absence of a co-ordinated policy, financial resources and lack of will among senior policy-makers and officials are serious impediments to protecting children from violence, abuse and exploitation. Various ministries have adopted piecemeal approaches and, while some of these initiatives are making progress, a concerted prioritization would multiply positive effects.

The NPPs, one such initiative, were formulated by the Government and approved at the 2012 Tokyo Conference. Although NPP 22 refers to the AIHRC's duty to monitor respect

for women's and children's rights and NPP 1 refers to child labour, the Government missed several opportunities to include explicit considerations for child protection. Given that 80 per cent of donor aid is aligned through the NPPs, funding large-scale efforts to protect children is less likely.

The 2006 National Strategy for Children at Risk is the Government's most comprehensive and focused policy for child protection. It outlines the vision for a network of services, policies and programmes necessary to protect children at risk and enable them to reach their full potential.

The Government has also committed to an Action Plan eliminating under-age recruitment to the Afghan National Security Forces, including the police. However, its ability to deliver on this commitment depends on the effective implementation of other policies. These include alternative employment for family breadwinners, birth registration and identity cards, and punishment for those who recruit children in armed forces or armed groups.

In 2010, six national ministries, the Supreme Court, the Attorney General's Office and the National Directorate of Security signed an agreement to contribute to a child-oriented and rights-based juvenile justice system. This would respect children's rights and pursue best interests of children, prioritize their rehabilitation and reintegration, and ensure that custodial sentences are short and used only as a last resort.

Key programmatic approaches

There is still no unit or ministry responsible for co-ordinating implementation of the CRC, despite the CRC Committee having recommended the creation of such an oversight body. A proposed Child Protection Secretariat under the National Strategy for At-Risk Children has yet to be operationalized.

One success under the National Strategy, however, has been the formalizing of the CPAN.¹⁰¹ This is an inclusive network of government and non-governmental organizations with a mandate to intervene in the area of child protection. CPAN members provide case management services for children with urgent protection needs as well as regular opportunities for communities to develop their understanding of child protection issues. In addition to the national network, there are



/// FROM THE FIELD

In desperation, Farzana's mother Habibe alerted local members of the Child Protection Action Network, which is supported by UNICEF. These men along with a local religious leader, Sultan Mohammad Yusufzai spent three months convincing Farzana's

father and the groom to cancel the wedding. "The main reason for child marriage is poverty and that forces parents to agree to early marriage. The second reason is low awareness among families about international human rights," says Sultan Mohammad Yusufzai.

28 provincial and 54 district CPANs.

The Afghanistan Protection Cluster was established in 2008 to strengthen the co-ordination of humanitarian action in response to the needs of crisis-affected groups, communities and populations, including people displaced by war, armed conflict, persecution and disasters. A continuing challenge for the Cluster and its associated sub-clusters is the limited experience and capacity of the participating NGOs.

Budget allocations

Currently, the national budget apportioned to building and strengthening child protection services is negligible. It is grossly inadequate for developing the holistic framework necessary to prevent and respond to violence, abuse and exploitation.

Given the multi-disciplinary nature of child protection, it is difficult to determine the exact budget allocation. But the development allocations according to the Government operating budget – 43 per cent for security, 15 per cent for education, 4 per cent for health, and just 1 per cent for social protection (where many child protection activities are located) – reflect poor national prioritization for children. The Government's failure to specifically identify child protection within the 22 NPPs means donor assistance will shrink further in the coming years.

Human resources and capacities to deliver services

Legislative and policy frameworks alone will not automatically lead to the effective protection of child rights. Pre- and in-service training for all relevant professionals with a duty of care towards children must explicitly address child protection issues. In addition, increased public awareness around child rights and child protection issues is needed to support efforts for prevention and response to violence, abuse and exploitation.

Because the child protection 'system' is still weak, in most areas its success or failure in responding appropriately boils down to people's individual capacities. Those working in fields such as law enforcement, social work and birth registration face common challenges: poor staff retention due to low salaries and perceptions that government workers are parties to the conflict; lack of female staff; and low levels of awareness on child rights. Development partners have provided training, coaching and mentoring for staff in the Government, AIHRC and civil society organizations, and have placed technical experts within ministries to help with policy and programme development as well as monitoring and evaluation.

The coverage and quality of social welfare services is extremely limited in Afghanistan. Social work is not recognized as a profession and most welfare workers are either untrained

or inadequately trained. CPAN's capacity to respond to child protection concerns is limited by the lack of services such as post-trauma counselling, shelters for children who need separation from their families, and educational or vocational programmes for at-risk children.

The Committee on the Rights of the Child noted the establishment of the Child Rights Unit at the AIHRC as a positive development and recommended that it receive adequate funds and training to perform all functions in its mandate.¹⁰² The unit undertakes monitoring visits to children in juvenile rehabilitation centres and orphanages even though its monitors are, on occasion, blocked from entering certain facilities.

Strategic areas for action

- **Encourage changes in social norms.** Prevailing social norms that accept, encourage or perpetrate violence, abuse and exploitation of children must be challenged. These norms are detrimental to children's survival, development and protection and hence their future. Understanding what drives this violence, consistent messages about its dangers and unacceptability, and encouraging alternative behaviours must be encouraged. These are positive means of enabling families and communities to form the first protective layer to which children are entitled.

- **Provide adequate, accessible and acceptable services for child survivors of violence, exploitation and abuse.**

This might include appropriate medical assistance from well-trained professionals, psycho-social support, legal advice, and shelter, and allowing children to be separated from their parents if necessary. The judicial system should be capable of prosecuting perpetrators of crimes against children.

The isolation and suspicion faced by child victims of abuse further victimizes them. Changing the perception that an abused or violated child somehow 'deserves' the situation is vital. Holistic support available to child victims of violence is currently almost non-existent. Victims are largely dependent on their family's or community's readiness to provide support. As their technical and advocacy capacities increase, service providers for child victims may also become 'champions' for the change in social norms.



Health & Nutrition

Status and trends

Maternal mortality

The maternal mortality ratio (MMR) in Afghanistan has been reduced from 1,300 per 100,000 live births in 1995 to 460 per 100,000 live births in 2010, an encouraging fall of 65 per cent. But the country still needs to reduce the current ratio by a further 30 per cent to meet the MDG5 target of 325 per 100,000 live births by 2015.¹⁰³

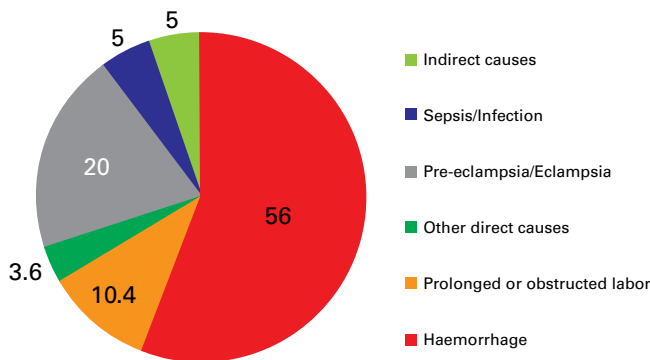
Despite the dramatic decline in maternal mortality, the Afghanistan Mortality Survey (AMS) for 2010 shows that pregnancy related causes of death remain the leading risk for women in their child-bearing years (41 per cent). Under current conditions, a woman has around a 1-in-32 risk of dying from pregnancy related causes during her lifetime.¹⁰⁴ Some 41 per cent of deaths occur during pregnancy, 40 per cent during delivery, and 19 per cent in the two months after delivery.

There are significant variations in maternal mortality ratios across the country associated with women's wealth status, level of education and place of residence. High fertility, poor antenatal care, low rates of skilled attendance at birth, adolescent

pregnancies, low rates of contraceptive prevalence and maternal malnutrition are the major underlying causes of maternal deaths. A WHO study found that unequally distributed health care services and lack of obstetric care in rural areas was a major contributing factor to the high rates of maternal deaths during pregnancy.¹⁰⁵

Haemorrhage is by far the leading cause of maternal deaths in Afghanistan, followed by eclampsia and prolonged or obstructed labour. Approximately 5 per cent of maternal deaths are attributed to sepsis.

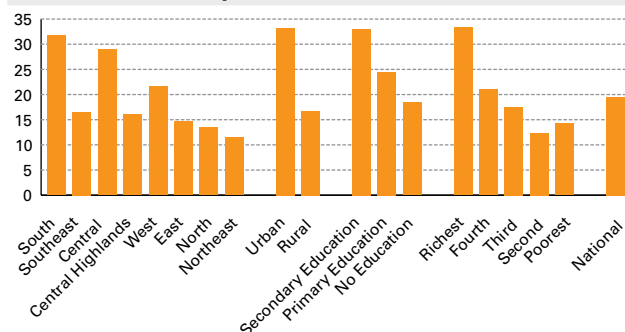
Recent data indicates that fewer than half of all women (47.9 per cent) used skilled antenatal services at least once.¹⁰⁶ There were huge disparities between women in urban and rural areas: 77 per cent of urban women used such services compared to only 41 per cent in rural areas. Only 14.6 per cent of women had the recommended four antenatal check-ups. The quality of antenatal care is inconsistent, with recommended practices applied only in a minority of cases. Only 41 per cent of these women were protected against tetanus, while only 12 per cent had their blood pressure measured and their urine and blood tested.

Figure 16 Causes of Maternal Deaths

Source: Afghanistan Mortality Survey, 2010

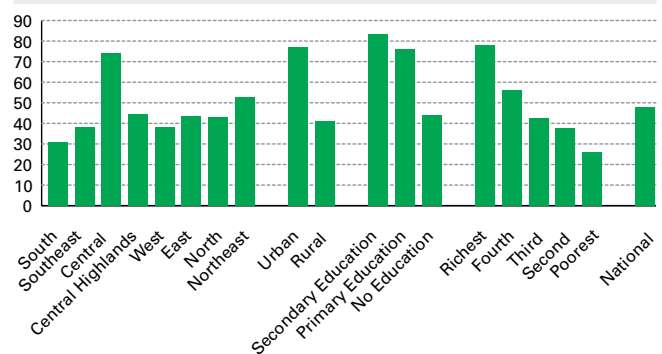
The proportion of women delivered by a skilled birth attendant is very low in Afghanistan at 38.6 per cent while 25 per cent deliver with the help of a relative or a friend and 30 per cent use traditional birth attendants. Again, there is an urban-rural divide, with 74 per cent of urban women benefitting from skilled birth attendants as opposed to only 30 per cent of rural women.

Early and child marriage carries with it significant risks for adolescent girls; the youngest first-time mothers bear the highest risks of maternal morbidity and mortality. In Afghanistan, 14 per cent of girls and women aged 15-19 years surveyed had already started child-bearing, with 9.7 per cent having had a live birth and 4.2 per cent being pregnant with their first child.¹⁰⁷ The 2010 Afghanistan Mortality Survey revealed that nearly one-third of all deaths of girls aged 15-19 years were pregnancy related.

Figure 17 Percentage of Women (ages 15-49 years) Currently Married Who are Using Any Modern Contraceptive Method

Source: MICS 2010/11

One in three married women under 30 years of age is pregnant. Use of contraception is low. Less than 20 per cent of married women use any modern method of family planning. Women in urban areas are more likely to use contraception than those from rural areas (33 per cent compared with 17 per cent), while women with secondary education are almost twice as likely to use modern contraception as those with no education (33 per cent versus 18 per cent).

Figure 18 Percent of Women (ages 15-49 years) Who Received Antenatal Care by Skilled Personnel¹⁰⁸

Source: MICS 2010/11

Malnutrition increases the likelihood of pregnancy- and birth-related complications, in addition to adversely affecting a mother's ability to recover from illnesses. Nutritional deficiencies and infections can lead to anaemia, which in turn puts mothers at risk of post-partum haemorrhage – the leading cause of maternal mortality in Afghanistan. Anaemia affects 40.4 per cent of women of reproductive age in Afghanistan, a consequence of infections and poor intake of food rich in iron and folate. Adolescent girls are also at increased risk of iron deficiency after they begin menstruating and because they are still growing. Pregnancy further increases their need for iron, folic acid and other nutrients.

Inadequate water and sanitation facilities, together with poor hygiene practices, make women vulnerable to infections during pregnancy that increase the likelihood of maternal death. Water-borne illnesses and infections can also contribute to malnutrition. The need to transport water – typically women's responsibility – can place additional stress on a pregnant mother and lead to complications. Additionally, poor hygiene practices in health facilities themselves can lead to post-partum infections.

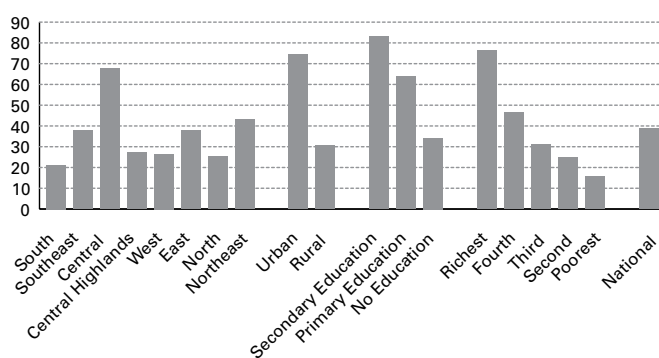


FROM THE FIELD

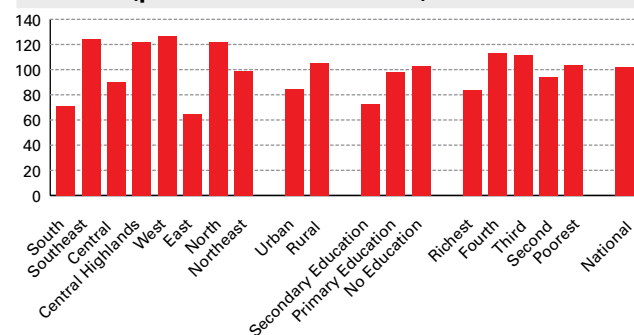
Fawzia, a 17 year old mother delivered twins at the maternity ward in Malalai hospital, Kabul. Both the babies were prematurely

born when the mother was only 32 weeks pregnant.

Only one child survived after delivery and was kept in an incubator until she stabilized.

Figure 19 Per cent of Women (ages 15-49 years) Who Had Their Delivery Assisted by Skilled Personnel

Source: MICS 2010/11

Figure 20 Under-Five Mortality Rate (per Thousand Live Births)

Source: MICS 2010/11

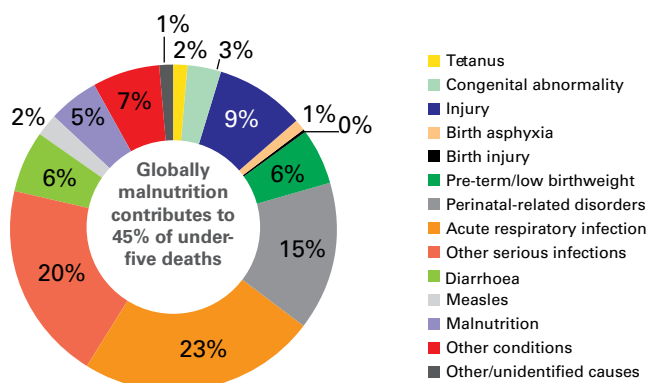
Child mortality

The under-five mortality rate in Afghanistan has almost halved from 192 per 1,000 live births in 1990 to 99 in 2012, a 48 per cent fall. The infant mortality rate also fell significantly, from 120 per 1,000 live births in 1990 to 71 in 2012. Despite these encouraging trends, the MDG4 target of reducing under-five mortality to 64 per 1,000 live births by 2020 will most likely not be attained.¹⁰⁹

According to the most recent global targets in "A Promise Renewed,"¹¹⁰ Afghanistan needs to reach an under-five mortality rate of 20 and a neonatal mortality rate of 10 by 2035. This would require an Average Annual Rate of Reduction (AARR) of 6.5 per cent in the under-five mortality rate compared with the current rate of 2.7 per cent. For neonatal mortality, the task ahead is even more daunting: the 2011 neonatal mortality rate is 36, so the current AARR of 0.1 per cent would need to increase to 5.2 per cent in order to meet the target. While the recent achievements are significant, programmes to improve neonatal and child health and nutrition need to be strengthened to accelerate progress if the new global commitments are to be met.

Infectious diseases accounted for more than half of the under-five deaths in 2010. Malnutrition (moderate as well as acute) is a cross-cutting factor that plays a part in 45 per cent of under-five deaths.¹¹¹

The high rate of under-five deaths due to pneumonia could be due to a variety of causes. Afghanistan is a mountainous country with a very cold winter and high altitude (Kabul is 5,900 feet above sea level), which makes children more vulnerable to respiratory diseases. Low immunization coverage is another important contributing factor.

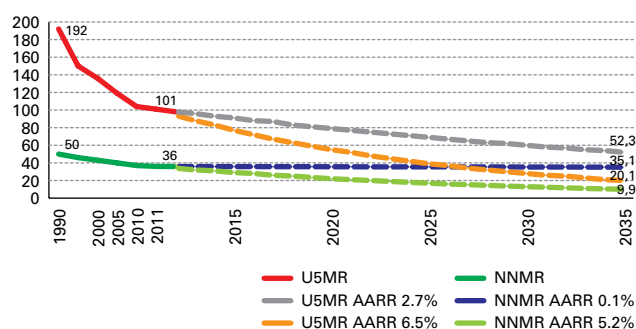
Figure 21 Causes of Under-Five Mortality

Source: AMS, 2010

Diarrhoea is the cause of death in 6.2 per cent of cases. Among the factors contributing to its high prevalence are poor nutritional status, lack of proper hygiene and sanitation, and sub-optimal infant and complementary feeding practices, together with the unavailability of the rotavirus vaccination.

The underlying factors influencing under-five mortality in Afghanistan include: access to immunization, access to quality neonatal and child health care, the nutritional status of children, mother's age at the time of delivery, care practices adopted by the family, access to safe drinking water, adequate sanitation, and food insecurity.

Afghanistan has low rates of full childhood immunization.¹¹² Only 30 per cent of children aged 12-23 months are fully vaccinated, while one in four children receive no vaccination in their first year of life. There are wide disparities between regions, ranging between 42 per cent full vaccination coverage in the Northeast to under 2 per cent in the South.

Figure 22 Trends in Under-Five and Neonatal Mortality Rates (per Thousand Live Births) (1990-2035)

Source: UN Inter-agency Group for Child Mortality Estimation. Levels & Trends in Child Mortality Report 2012

“Our data shows that there are around 4-6 premature births every day in this hospital.”

said Dr. Shahrbanoo,
chief of the children’s ward at the Malalai hospital in Kabul.



FROM THE FIELD

A fundamental component of UNICEF’s work is to support provision of health and nutrition

services for children and mothers.

“Our data shows that there are around 4-6 premature newborn births every day in this hospital.”

Said Dr. Shahrbanoo, chief of the children’s ward at the Malalai hospital, where Fawzia gave birth to her children.

Nationally, 57 per cent of households live within an hour's walking distance from a health facility 78 per cent among urban households and 54 per cent among rural ones.¹¹³ Access to safe drinking water is an important factor affecting children's and women's morbidity and mortality: 32 per cent of households in Afghanistan have improved drinking water on their premises, 66 per cent in urban areas and 25 per cent in rural areas. The picture is similarly dismal in relation to sanitation facilities: only one-third of the population lives in households using improved sanitation with a significant divide between urban-rural areas.

Nutritional status of children

While Afghanistan has made some improvements in nutritional status of children in the past decade, the rate of stunting in children under-five is high at 40.9 per cent.¹¹⁴ Stunting is recognized as a standard marker of failure in the early growth of young children and is closely associated with poverty and other dimensions of inequity. Undernutrition in infants is often also indicative of poor practices in the feeding of infants and young children. Poor access to health and nutrition services at the community level also contribute to the high prevalence of under-nutrition.

Table 4 Forms of Malnutrition in Children Under Five Years Old

Nutrition indicator	Estimated (%)	
	Moderate and Severe	Severe
Underweight	25.0	9.7
Stunting	40.9	20.9
Wasting	9.5	40.0

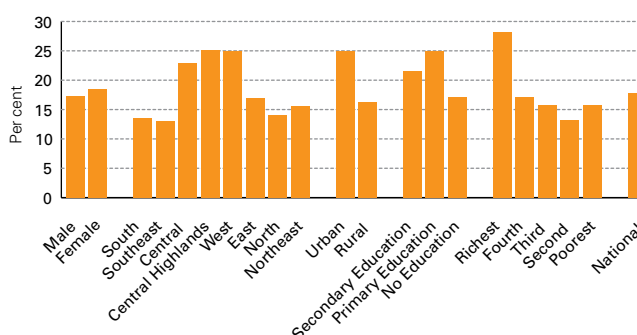
Source: National Nutrition Survey: Afghanistan, 2013.

Almost all Afghan babies are breastfed, but only 58.4 per cent of infants aged 0 to 5 months are exclusively breastfed.¹¹⁵ Even at the earliest ages, approximately 40 per cent of children receive liquids or foods other than breast milk, putting them at increased risk of consuming contaminated food and water.

Knowledge and awareness among caregivers and children, especially adolescents, is important for children's health and nutrition. Men in particular lack awareness of maternal and child health issues. In a patriarchal society where men make many decisions affecting the well-being of women and children, this is a matter of serious concern.

Poor nutritional status, including micronutrient deficiencies, significantly affects the long-term mental and physical capacity of Afghanistan's people. The high levels of stunting in young children require strategies beyond the health sector to break the inter-generational cycle of undernutrition for a genuinely multi-sectoral response.

Figure 23 Children (ages 6-23 months) Who Received the Minimum Number of Feedings During the Previous Day



Source: MICS 2010/11

Minimum meal frequency is one indicator of appropriate infant feeding. According to figure 23 only 17.8 per cent of infants aged 6 to 23 months received the minimum number of feedings. Poor feeding practices are evident across all geographic, wealth and educational categories. Infant feeding practices are not only affected by poverty, but also by a mother's education level of awareness and the extent to which social norms influence her decision-making.

Key strategies

Programmes in the sector are guided by the National Health and Nutrition Policy 2006-09 and the new National Health and Nutrition Policy 2012-20, which links to other policies and strategies.¹¹⁶ The vision of the MoPH for health in Afghanistan states that in 10 years (2004-14) better health will contribute to economic and social development. However, most of these policies need to incorporate a rights-based approach, focus on reducing disparities, and target more effectively underprivileged groups.

One of the most relevant instruments for better health is the National Child and Adolescent Health Policy (2009-2013). The policy and its related strategy "address the most prevalent threats to the survival of Afghanistan's children using feasible and affordable approaches that can assure over time national coverage with interventions reaching into every community and home."¹¹⁷ The strategy also recognizes the importance of maternal health care as complementary to child and adolescent health. Therefore, the strategy prioritizes interventions that will have the greatest impact on maternal, child and adolescent mortality. The policy and strategy emphasize the need to focus on strengthening the first line response at the community level. The strategic directions to improve child, adolescent and maternal health include: effectively target the most vulnerable, poor and disadvantaged, improve efficiency and quality of service delivery, engage and empower families and communities, improve leadership and governance for child survival, consolidate partnerships, and ensure financial support for child survival. The MoPH has also taken steps to mainstream gender into its service delivery through the introduction of the National Gender Strategy (2012-2016).

There is need for a long term vision to develop the health system and sustainability of health services in Afghanistan. Currently, financing of the health sector is almost entirely dependent on external funds; the health workforce is inadequate, imbalanced (both in gender and geographical distribution) and unevenly distributed with inappropriate skills mix and lack of specialist services such as nutrition. The physical infrastructure of the health system is inadequate and delivery of health services relies heavily on contracting out of the Basic Package of Health Services (BPHS) and the Essential Package of Hospital Services (EPHS) to NGOs. The current situation may continue in the near future. However, the MoPH has the challenge and responsibility to come up with options and strategies that would allow the health system to sustain itself and ensure essential public health services function over the longer term.

In addition, weak government capacity, particularly in areas of policy analysis, strategic planning, human resource planning, standard setting, health legislation and regulation and health financing seriously affect health service delivery.

Key programmatic approaches

The Afghan health system has been substantially rebuilt in the past decade and signal functions, key interventions to prevent or treat major causes of morbidity and mortality, are improving. Health services are delivered through five outlets in Afghanistan:

1. Community level through volunteer Community Health Workers;
2. Health Sub-centres and Mobile Clinics;
3. Basic Health Centres, Comprehensive Health Centres, and District Hospitals;
4. Provincial and Regional Hospitals; and
5. National and Speciality Hospitals.

In 2003, the Ministry of Public Health established an integrated BPHS aimed at providing a minimum package of primary health care services, with the specific aim of reaching those in remote and rural areas. The programme has a strong focus on maternal and child health. Interventions selected as part of the programme at each of the five levels seek to reduce mortality and morbidity and promote equity.¹¹⁸ The BPHS is delivered mainly through national and international NGOs that are contracted and overseen

by the MoPH. In 2006, some 82 per cent of Afghans lived in the districts where primary care services were provided by NGOs.¹¹⁹ Ineffective communication and coordination between NGOs and the Government together with inadequate consultations with the community they serve has resulted in inefficient service delivery characterized by duplication or gaps in services.

The EPHS was introduced at the same time as the BPHS in order to complement and support primary health services. The combination of the two programmes has greatly increased health service coverage for mothers and children. However, a majority of the services are urban and facility-based with poor links to rural and remote communities. Further impeding health care is the poor functioning of the referral mechanisms both vertical – from primary to secondary to tertiary – and horizontal, for example, between hospitals.

A critical component for the functionality of the primary health care system is the cadre of community health workers (CHWs). This group of service providers are expected to be the first-line responders, performing several tasks in health care delivery, but they receive no formal payment. This is a fundamental flaw in the system and effectively means there is little or no investment in primary health care at the community level.

While immunization services are part of the BPHS and supported by the National Expanded Programme on Immunization (NEPI), progress on immunization coverage has been slow in recent years. This is attributed in part to the low salary and lack of job security of the second male vaccinators who are temporarily filling positions of female vaccinators. Moreover, the monitoring and accountability by the NEPI and its provincial equivalents are grossly inadequate.

The nutrition component of the BPHS faces serious problems due to lack of capacity and resources to deliver the service. However, national laws controlling the unethical marketing of breast milk substitutes and regulating the iodization of salt have had some positive impact.

The lack of trained, motivated and accountable staff reduces effectiveness of the BPHS programme, limiting appropriate treatment and prevention of the immediate causes of maternal mortality.



FROM THE FIELD

Bibigul Momand, a midwife who has assisted more than a thousand deliveries counsels women in Jaghatai Village, Herat, western Afghanistan as part of a UNICEF-funded mobile medical team.

Trained mobile medical teams visit villages that are more than 25 kilometers away from the nearest hospital or health center. These mobile teams include a midwife, vaccinator and a nurse. The team of three works hard to counsel, vaccinate and treat women and children.

The MoPH directs and monitors the implementation of the BPHS through the Health Management Information System (HMIS), while third parties evaluate service delivery through facility- and community-based surveys. NGOs also play their part in implementing primary health care. Meanwhile, high demand for certain health services, particularly those delivered by female staff, has prompted involvement of the profit-making private sector.

There have been some discussions between the three main donors to the health sector about creating a common funding mechanism that would make a Sector Wide Approaches (SWAp) more feasible. A SWAp would also facilitate aid coordination, replacing multiple bilateral meetings between the MoPH and its development partners.

Nutrition, for example, necessarily involves multiple sectors, including health, education, food, agriculture, water and sanitation. Efforts are therefore being made to establish a secretariat under the leadership of the Second Vice President that would co-ordinate initiatives under a Nutrition Action Framework.

Budget allocations

Financing for health services comes from the Government, donors and from out-of-pocket payments made by individuals using services. Government services are funded by three main donors – the World Bank, USAID and the European Commission. The majority of funds go to supporting primary health care (BPHS), with lesser budgets allocated to secondary and tertiary hospital service delivery (EPHS). Donors provide more than 90 per cent of the expenditure on primary health care.

According to a recent report by World Bank, total public spending on health in 2008-09 was \$277.7 million, 85 per cent of which came from external assistance.¹²⁰ Total per capita health expenditure (not including money spent on food and transport) is estimated between \$19.25 and \$34.65,¹²¹ which exceeds the World Health Organization (WHO)'s minimum for low-income countries. This would have been even higher had the survey covered urban areas, where the private sector plays a major role in health care. In the absence of a robust community health infrastructure that can effectively meet community's health needs, the out of pocket expenses for seeking health care are either spent on expensive medicines or for reaching a health provider. The lack of a health insurance system in Afghanistan means that out-of-pocket

payment is the main source of private expenditure on health and accounts for up to 79 per cent of total health spending.¹²²

Overall, the Government's budget allocation is aligned with children's and women's health needs as outlined in the ANDS and the NPP, with particular emphasis on MDG4 on child mortality and MDG5 on maternal mortality. The budget for training CHWs on the Integrated Management of Childhood Illnesses has a direct impact on children's health and under-five mortality. The budget is, however, not sufficiently gender-responsive as, for instance, the allocation for women's health including reproductive health is very low.

Given the critical need for investment in maternal and child health, it is of grave concern that the share of the Government budget allocated to the MoPH was cut from 4.6 per cent in 2012 to 3.7 per cent in 2013. Although the MoPH has one of the highest rates of budget execution among ministries, it is still much too low, around 60 per cent.¹²³

Human resources and capacities to deliver services

Afghanistan has around 20,000 registered health workers, of whom 40 per cent are employed by the Government and 60 per cent by the private sector (including NGOs).¹²⁴ This amounts to just 5.6 public sector doctors, nurses and midwives per 10,000 people, compared with the WHO minimum of 23 per 10,000. There are stark spatial disparities as well. According to the MoPH's National Health Workforce Plan (2012-2016), in rural areas there are around 17 public health workers (including support staff) without proper health related qualifications compared to 36 per 10,000 in urban areas.¹²⁵

The main human resource challenges in health are the imbalances in:

- **Urban-rural** – health workers are highly concentrated in urban areas
- **Gender** – there is a shortage of female staff, especially in rural areas
- **Skills** – there is a shortage of staff skilled in nutrition, public health, reproductive health, and child health

There are stark disparities between the availability of health professionals, particularly female health care workers across provinces. The lack of female health care providers is a significant barrier to women and girls accessing health care.



FROM THE FIELD

The midwife counsels new mothers and talks about the importance of exclusive

breastfeeding and other recommended behaviours to be taken before and after child birth.

According to HMIS data for 2010/2013, females account for less than 10 per cent of all health care workers in Paktika, Zabul and Urozgan. There was not a single female nurse in either Parwan or Urozgan in 2010/2013.¹²⁶ Kabul, Kunduz and Nimroz have the best female ratio for its health care workers. In each of these three provinces females account for around 40 per cent of all health care workers. See Annex 7 for health facilities and workforce by province.

Health organizations in insecure areas have much more trouble recruiting qualified health staff than in peaceful provinces. Stakeholder interviews in Kandahar, for example, indicate that there are only one or two female doctors working in the BPHS clinics in the whole province. Most doctors' positions are actually occupied by male nurses – only 10 of the 40 clinics in the province have a male doctor. Interviews suggest that security is not the only issue, low pay is also a factor.

There are several barriers at the facility level that prevent women from accessing health care. The two most important factors are the lack of female health care providers, and the quality of care provided.¹²⁷ According to a literature review carried out in 2013 on the determinants of gender sensitivity in the health care system, other obstacles that prevented women from accessing services include “lack of 24x7 maternal health services provided by female staff, long waiting time, and facilities not having separate waiting areas for men and women. A lack of empathy and providers' poor communication skills are also highlighted as common reasons why women do not visit health facilities. It is a shared belief that male providers are less attentive than female providers.”¹²⁸

There are significant differences between provinces with regard to the availability of trained staff, particularly trained female staff. There is, therefore, an urgent need to increase the number of trained health staff, particularly by promoting continuing medical education programmes for staff in insecure areas. Training people in their own localities is more likely to address the problem than persuading trained staff to relocate to remote or insecure areas.

In addition, there is a virtual absence in the country of a primary health care workforce. There are currently around 24,000 community health workers who are supposed to play an important linking role between the health facility and the community, with special responsibility for social mobilization. Because their contribution is voluntary, there is little evidence on how effectively they deliver services. This huge workforce, if properly trained, incentivized and remunerated can represent the potential future of Afghanistan's health system.

Nutrition services are limited in Afghanistan and there are no dedicated health care providers who can offer counselling on maternal and child nutrition or properly measure the different types of undernutrition prevailing. As a result, rates of stunting, severe acute malnutrition and micronutrient deficiencies may be underestimated and receive much less focus than they deserve.

Demand-side barriers to service utilization

The private and public sectors in rural Afghanistan are broadly complementary. The public sector focuses on preventive care and maternal and child health and the private sector on curative care for adults. This is largely based on demand. Households are more likely to seek public sector care for children's routine check-ups (81.5 per cent) and illnesses (41.4 per cent) than for adults' (31.9 per cent and 28.6 per cent respectively).¹²⁹ In contrast, private providers are preferred for adult health care despite being more expensive. Although it costs 3.8 times more to visit a private physician than to attend a community health centre, there are over 65 per cent more visits to the former than to the latter.¹³⁰

Demand for religious and traditional health providers is also high. Many people have faith in the ability of religious leaders to cure their health problems. Religious leaders provide *taweez* – written verses of the Qur'an wrapped in a piece of cloth – to treat epilepsy, jaundice and some mental health problems. In general, however, the use of traditional providers does not prevent people from seeking modern medical care – they often use both.

The poor are less likely than the better off to use health facilities. The MICS 2010/11 indicates that 76 per cent of women in the wealthiest quintile had a skilled birth attendant during delivery compared with just 16 per cent from the poorest quintile.¹³¹ To a large degree this is explained by the distance of their homes from health posts or clinics. World Bank research found that 54.3 per cent of households in the poorest quintile lived more than six hours from a health facility, compared with only 3.8 per cent of households in the wealthiest quintile.¹³²

The use of reproductive health services is generally low but is further reduced by distance. Pregnant women who live more than six hours away from a health facility are 25 per cent less likely to use a skilled birth attendant than those who are less than two hours away. This relationship is reflected in maternal mortality ratios, which are very high in remote and rural areas. Distance from home is not the only factor here. Rural facilities are also less likely to have skilled female health workers.

Distance also has an adverse effect on the immunization of children: BCG vaccination rates for children who live more than four hours from a health facility are only 60 per cent of those who are less than two hours away.¹³³ The smaller gap for OPV3 and measles vaccination may be attributed to national immunization days, which carry the services deeper into rural areas.

Representative group interviews in Parwan, Jalalabad, Mazare-Sharif and Kandahar suggest that most people are not aware of their health and survival rights. The long-term political instability is partly responsible, as is the inadequate provision of health services, but much more can be done to foster awareness through community mobilization programmes and mass media.

POLIO ERADICATION

The Global Polio Eradication Initiative (GPEI), that aims to eradicate the wild polio virus, a crippling disease affecting children, has now entered its most critical, and hopefully final phase. As a result of intensive worldwide efforts to eradicate the disease, Afghanistan is now one of the only three countries in the world where the disease remains endemic. The other two countries are Pakistan and Nigeria.

Following years of decline in the number of cases with just 25 cases reported in 2010, Afghanistan had a major outbreak in 2011. The outbreak resulted in 80 cases, with all regions of the country reporting cases. It brought home the need to introduce new approaches and redouble existing efforts to ensure every child is immunized. These strategies include district-specific plans to ensure vaccinators have access to communities and communications campaigns and social mobilization to raise awareness and generate demand.

These strategies have resulted in significant gains in terms of accessibility and increasing awareness. In 2012, 30 cases were reported and in 2013, the number of reported cases was cut in half to 14. Transmission has largely been confined to the East and Southeast Regions but other parts of the country remain at risk to outbreaks due to population movements, areas being inaccessible to vaccination teams due to insecurity and conflict and low community demand for vaccinations.

Further, a sizeable number of children within accessible communities still miss out on being vaccinated for various reasons. As outlined in the Polio Eradication and Endgame Strategic Plan 2013-18, for Afghanistan to interrupt wild polio virus transmission these missed children need to be 'accessed' and vaccinated, especially during the high transmission season.

Female front-line polio workers hold the key to eradicating polio from Afghanistan. In socially conservative communities where polio still persists today, cultural norms often do not allow male vaccinators to enter a home, or even communicate with women on the doorstep. Female vaccinators are able to speak woman to woman; they convince mothers to vaccinate their children. They are 12 per cent of Afghanistan's campaign workers.



Socio-cultural sensitivities also affect demand for health services. Women seeking antenatal care, for example, are unwilling to be seen by a male doctor or nurse and the shortage of female service providers in rural areas limits their options for skilled care. Fear of international coalition forces has also been a factor deterring women in particular from visiting health centres in some areas, particularly during the night. There is anecdotal evidence that people living in villages surrounded by foreign troops do not dare to pass them to visit a clinic, even if their health problems are serious. In some areas this obstacle has been surmounted by providing an ambulance service for emergency cases.

Social norms and low status of women seriously threaten women's health. A substantial proportion of the population wants to limit fertility yet traditional gender roles promote high fertility. Women's lack of autonomy is a serious constraint in seeking and receiving needed care. Cultural restrictions on the mobility of women are a significant constraint to women accessing maternal health and other services. Most women do not have permission to move about freely and they are forbidden to visit some places alone. The practice of *purdah* or seclusion of women makes it difficult for women to obtain social and health services including for maternal health. The cultural practice of keeping newborns inside the house for forty days makes newborns invisible to the health system.

Strategic areas for action

• Improving access to and utilization of health services

Around 57 per cent of the Afghan population has access to any health facility within one hour's walking distance,¹³⁴ and 38 per cent have an accessible BPHS facility, but the use of services remains low. Access is better in urban areas than among the rural and Kuchi populations. Therefore, community-based interventions targeting rural and under-served areas must be refocused. High out-of-pocket expenses must be reduced by strengthening basic and hospital services and improving quality of care in health facilities.

The health service should also be made gender sensitive. Given the social norms in Afghanistan, women usually want to see female staff, in addition to being accompanied by a man if they are even to visit a health facility. The health service needs to have a concerted, proactive policy in recruiting more women, especially to posts delivering services to women and children.

• Making nutrition a priority

Reducing the stunting of children should be a priority and integral to the national strategy. Recent data from the first national survey in ten years provides new evidence on the caseload and approximate distribution of undernutrition across the country. A multi-sectoral approach is needed to combat food insecurity, enhance food production, improve food processing and especially, to raise awareness of healthy feeding practices through media campaigns at all levels and community campaigns.

• Improving immunization services

A thorough review of immunization systems is needed, which must involve: revising the EPI policy, streamlining data, improve micro-planning, effective vaccine and cold-chain management, strengthening supportive monitoring mechanisms, and a comprehensive communication strategy.

• Strengthening the primary health care workforce

The role of community health workers is vital. Yet they are currently unpaid and there is no formal monitoring of their work. Community health workers need a clear and accountable job description that formalizes their role as the link between the community and facility-based services. They also need to be paid and several pilot projects are exploring the idea of performance-based incentives. In addition, the number of midwives from rural locations needs to be increased and incentivized to work in remote and inaccessible areas.

• Data streamlining

In an efficient health system, disaggregated data is collected and used for evidence-based decision-making. In Afghanistan, the health sector has limited capacity for research and the HMIS is limited to the BPHS and the EPHS. Data are generated from different sources in an uncoordinated way and research conducted is inadequately linked to strategic policy-making. The collection of data needs to be streamlined and gathered on a more strategic basis that reflects public health needs.

• Improving the management of procurement

The MoPH currently has no mechanism for the procurement of medical equipment and supplies, slowing down delivery of health services – donor agencies and BPHS implementers do their own procurement – which results in a wide variation in the quality of medical goods supplied. The MoPH needs to reduce its dependence on donors and take on the role of consignee, as is the common practice in other countries.

• Improving governance at national and subnational levels

Capacity at the national and subnational levels on strategic planning, human resource planning, decentralized planning and management should be developed further. Mechanisms to ensure coordination between the central and provincial levels should be strengthened.



Education

Status and trends

There has been real progress across much of the education sector in Afghanistan, especially in increasing the inclusion of girls. But that progress is fragile and limited in reach, depth and sustainability, especially for those children living on the geographical and social margins of the country. Girls still do not have equal access. Enrolment ratios vary dramatically across provinces. In provinces such as Nuristan and Laghman, nearly all school-age girls are enrolled. However, provinces such as Zabul and Helmand see negligible proportion of girls enrolled in schools. Nuristan is the only province where the Gross Enrolment Ratio¹³⁵ (GER) for girls outpaces that for boys (see table 9). The situation in other provinces such as Laghman, Herat, Daikundi, and Badakhshan suggests that supply-side factors instead of gender may be more influential determinants of education indicators.

Much of the progress made in education so far has benefited from large inputs of external capital and technical assistance over the past decade. This will be threatened by the expected reduction in the education budget from 1.5 per cent to 1 per cent of the GDP.

Improvements in access to schooling were evident in the 2010/11 statistics that showed 7.5 million children in primary and secondary school up from 900,000 in 2001. The number of students enrolled has gone up 29 per cent since 2007. The Government has a target to double the number of children in school by 2020 and for all teachers to have the equivalent education credentials of two years of tertiary education. The highly uncertain socio-economic environment, however, makes these targets look optimistic. Although continued and new external funding may support teacher training, development of materials, and community-based education (CBE), there remain significant challenges in the most vulnerable districts.

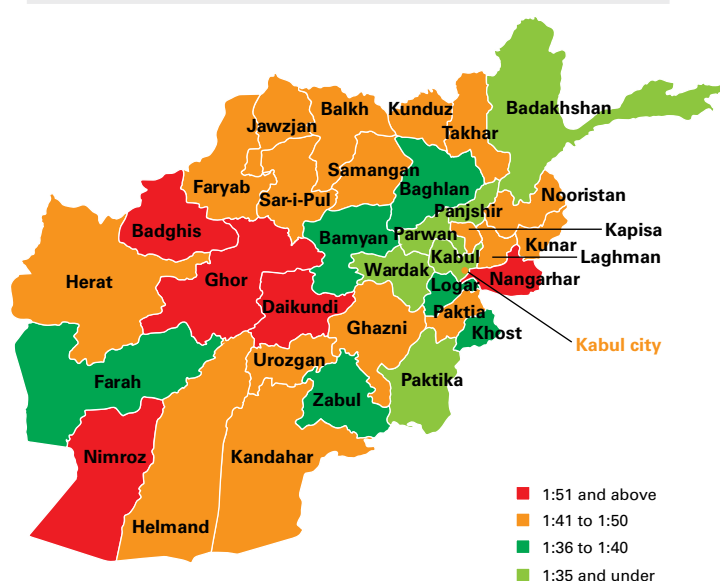
The number of schools has grown from 6,039 in 2002 to 15,510 in 2012, but these are still not enough to meet the demand.¹³⁶ Of these, 16 per cent are for girls and 30 per cent are for boys. The remaining 54 per cent are mixed, but students in these schools lose teaching time as girls and boys have separate half-day sessions. Even if 500 new schools are created annually, it will take 13 years to meet the rising demand. Meanwhile, teacher-student ratios are

already expected to rise to 1:50 or 1:60, far above the target of 1:35.¹³⁷ Only five provinces meet the current target ratio as indicated in the map below. The widest gaps in student to teacher ratios are in Badghis, Nangarhar, Ghor, Nimroz, Daikundi, Nuristan, and Urozgan, indicating that these provinces face challenges in attracting teachers.

Table 5 Gross Enrolment Ratios* by Province and by Sex for 2011/2012

Province	GER		
	Total	Male	Female
Nangarhar	1.02	1.16	0.85
Nuristan	0.97	0.72	0.91
Nimroz	0.95	1.07	0.83
Laghman	0.93	0.94	0.92
Kunar	0.87	0.99	0.75
Herat	0.86	0.87	0.85
Balkh	0.83	0.89	0.76
Daikundi	0.8	0.72	0.75
Baghlan	0.77	0.94	0.59
Badakhshan	0.72	0.72	0.72
Takhar	0.72	0.79	0.63
Jawzjan	0.69	0.78	0.6
Ghor	0.67	0.72	0.52
Kunduz	0.66	0.79	0.52
Bamyan	0.66	0.72	0.61
Khost	0.65	0.72	0.35
Kabul	0.64	0.7	0.59
Faryab	0.62	0.69	0.55
Badghis	0.59	0.82	0.34
Ghazni	0.57	0.71	0.41
Samangan	0.57	0.66	0.47
Paktika	0.57	0.72	0.24
Panjshir	0.54	0.72	0.51
Sari-Pul	0.53	0.72	0.46
Paktia	0.52	0.74	0.28
Farah	0.46	0.58	0.32
Urozgan	0.44	0.72	0.12
Parwan	0.42	0.5	0.33
Wardak	0.37	0.48	0.24
Kapisa	0.31	0.39	0.23
Kandahar	0.29	0.42	0.16
Logar	0.26	0.33	0.18
Helmand	0.25	0.39	0.11
Zabul	0.16	0.24	0.07
Total	0.62	0.72	0.51

Map 11 Student to Teacher Ratio (STR) by Province**



Source: Calculated from EMIS data 2011/12

School facilities are often poor: some 5,000 are “without usable buildings, boundary walls, safe-drinking water or sanitation facilities.”¹³⁸ Too many of them, moreover, are not secure. Learners in 16 provinces had no access to schools in 2013 due to insurgent attacks and threats that led to the closure of about 500 schools.¹³⁹

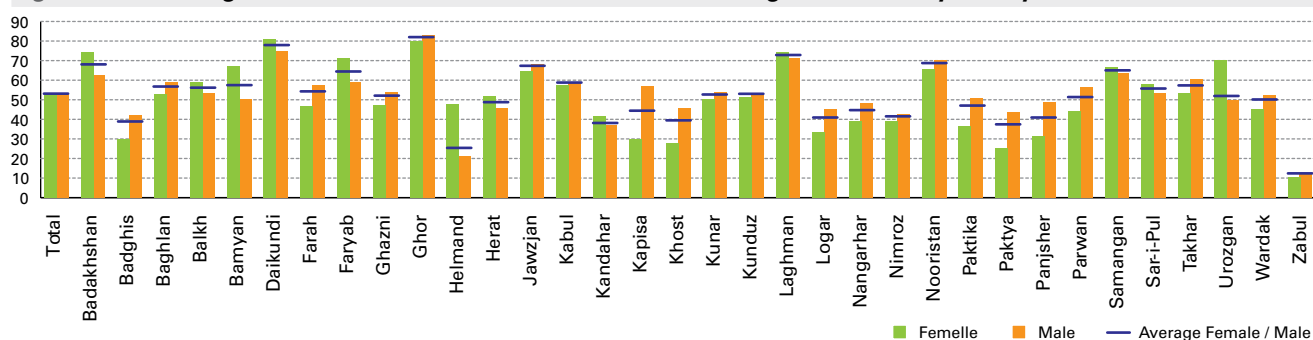
There is huge challenge in terms of space and hiring qualified teachers.¹⁴⁰ Several thousand teachers have received in-service training encouraging child-centred, girl-friendly and active-learning pedagogy. However, much of this has been short-term, and there has been little or no assessment of the benefits for students.

Access is not equitably distributed. Urban primary enrolment is much higher than rural, while more boys enrol than girls in both urban and rural areas.¹⁴¹ While enrolment for Afghan girls increased between 2007/08 and 2010/11, enrolment of boys dropped by 3 percentage points.

Gender equality remains an unacceptable missing outcome from almost all aspects of education and learning. Data suggests that reasonable levels of initial girls’ enrolment (41 per cent in Grade 1 are offset by lower participation at each of the subsequent grades, falling to just 28 per cent by Grade 12.¹⁴² Gender differences in the survivability to Grade 5 are illustrated in Figure 24. While there are no overall gender differences in survival rate to Grade 5, there are very large variations between provinces. Girls’ enrolment is often barred due to a number of exclusionary factors: forced or early marriage, social norms against girls being in public spaces, and the unacceptability of male teachers for older girls (there are no female teachers in over 50 per cent of

*Gross Enrolment Ratios include both primary and secondary schools

**STR includes both primary and secondary schools

Figure 24 Percentage of Students Who Enrol in Grade One Reaching Grade Five, by Sex by Province

Source: Calculated from EMIS 2011/2012

districts). However, there are some provinces where girls stay in school longer than boys: Badakhshan, Paktya, Khost and Panjsher. This girls' advantage is reversed in provinces such as Helmand, Urozgan and Bamyan. These figures suggest that boys should have greater roles and focus in gender equality discussions, not least given that, as men, they will play a major part in changing the thinking about gender.

There are persistently low rates of literacy and significant gender and rural-urban gaps: 62 per cent of urban men and 33 per cent of urban women are literate, compared with only 35 per cent of rural men and 7 per cent of rural women. Primary education, however, appears to be having an effect. A 2009 analysis by age showed that children aged between 12 and 16 years were significantly more literate than adults.¹⁴³

Key strategies

Schooling is, by law, supposed to be compulsory up to Grade 9 but there are insufficient numbers of schools and teachers to make this enforceable in the short term. The second National Education Strategic Plan (NESP) has set ambitious targets. By 2014, it aims to have 10 million students enrolled in 16,500 schools, and ensure that 80 per cent of teachers have passed the national competency test. The emphasis remains supply driven: inputs are to be provided and activities completed, but exactly what will change and for whose benefit is not clearly articulated. In addition, the needs of specific categories of children are excluded by current education strategies. These include children with disabilities, children who work, children from minority ethnic communities, and children who drop out or are permanently absent. The MoE is developing an inclusive education policy which addresses the needs of these groups.

The Policy Guidelines for Community Based Education (CBE) establishing Community Based Schools (CBS) and Accelerated Learning Centers (ALC) promises to increase access and equity to education. Community Based Education enables children in remote and marginalized areas to attend school in their communities. Meanwhile, children who are too old to enrol or have dropped out before completion, or need to combine work and school, are reached through ALCs. Evidence so far indicates that these schools are playing a crucial and effective role in providing access to education for girls and marginalized children possibly because these schools are located close to home and are taught by local teachers whom the parents trust.

In order to address the shortage of female teachers in rural schools, the Government has put in place a strategy for increasing female teachers in rural schools. So far they have focused largely on providing incentives for qualified urban teachers to transfer to rural schools. This and other strategies are costly, appear difficult to sustain, and have been met with limited success.

A serious underlying strategic failure has been insufficient emphasis on learning outcomes and on the quality of children's educational experience. High repetition and drop-out rates are emblematic of the problem, but not enough attention is paid to what is actually happening in the classroom on the quality of teaching and learning. Anecdotal reports indicate that there is too much reliance on learning by rote and too little on critical thinking or problem-solving. In addition, teachers are not setting learning objectives, assessing students' readiness or tracking their progress. Efforts to improve the curriculum and teacher training must take all these elements into account.

Key programmes

A number of local initiatives by agencies and NGOs are producing good outcomes, but a coherent system with a clear sense of direction is not yet evident. The two strategies mentioned above, CBE and ALC, are aimed at improving provision of educational access in rural areas and are showing some promise.

These two initiatives provide a platform through which the MoE and partner agencies can bring co-ordinated benefit to excluded children. It is vital in terms of equality of rights that CBE is not a temporary arrangement, but rather an integral part of general education with the same curriculum, materials and expected learning outcomes. Building five to six CBE classes around a formal school hub should reinforce this goal. International experience suggests that this model can be effective in facilitating enrolment; providing access, supervising and training teachers; monitoring standards and guiding corrective action. It can also help in co-ordinating school and community action on child protection.

Interview data indicate that CBE classes are increasingly seen as the venue of choice by communities frustrated with the inadequate reach of formal schools, and fearful of Taliban's resurgence. Though limited resources, especially teachers, mean CBE classes stop at Grade 3, their success suggests

*"Our kids now learn many things.
Most nights they come home and
teach us about different issues."*

says Hajimir Ahmad,
seventy-six year old village elder.



/ FROM THE FIELD

When village elders in Sangbast village in western Afghanistan realized that the girls of the village were not going to school because the nearest school was very far away, they came up with a smart solution: they built a girls school in the village itself

by donating rooms and a piece of land. Today, nearly all girls from the village attend school. Seventy-six year old village elder, Hajimir Ahmad, donated his own land to build a girls' schools in Sangbast. He says he could not educate his daughters, but it's not too late for his granddaughters. "Before the school

opened nine years ago, the situation in the village was bad. Even from my generation people were illiterate, and illiterate people like me are blind. Our kids now learn many things. Most nights they come home and teach us about different issues."

they should be extended to Grade 6, an option some NGOs are already testing.¹⁴⁴

In addition, Accelerated Learning Centres classes provided under the CBE policy are proving effective for the inclusion of working children and secondary school girls who are at risk of dropping out. Girls' participation in CBE frequently exceeds that of boys. These classes tend to be closer to home and employ local, often female teachers.

Deploying female teachers to rural areas is a second issue on which collaborative action is being attempted. The focus at present, with Global Partnership for Education (GPE) funding, is on offering qualified urban women teachers well-salaried three-year contracts for moving to rural areas along with their families, though there is scepticism on how many of them will take up the offer.

A potentially more effective and sustainable approach has been the opening of satellite teacher-training colleges in rural secondary schools, mainly in girls' schools. Evidence suggests that rural women trained in this way – where they live, and learning collaboratively as peers – can become qualified teachers. Moreover, they know the community and are more likely to stay for the long term.

Budget allocations

The education sector received 12 per cent of the national budget in 2012 and only 6.15 per cent of the development assistance.¹⁴⁵ These figures suggest that building capacity for a viable, accessible and quality education system is a relatively low priority for both the international community and the Government.

Ninety per cent of this budget goes on salaries, leaving less than 10 per cent to cover the myriad of on-going challenges of low teacher qualifications, shortages of teaching and learning materials, and inadequate school infrastructure.¹⁴⁶ Literacy and Technical and Vocational Education Training (TVET) have about the same overall share of the funds that directly support learners, approximately 18 per cent. A general reduction in donor support could well lead to greater reluctance on the part of the Government to support higher cost areas such as TVET and functional life-skills literacy, which are critical to addressing the youth bulge and reaching the most excluded poor, including girls and young women.

Under-spending is also a problem in the sector, only 38 per cent of the budget was actually spent in 2011/12. According to the NESP III, currently being developed the "finance and procurement systems of the MoE are centralized, which limits the MoE's capacity in budget execution."¹⁴⁷

The sector has no shortage of areas where targeted funds could be quickly allocated to make a significant difference, such as school infrastructure, materials and teacher mentoring. With support, education authorities and *shuras* should be able to work with schools to identify legitimate needs, prioritize action and monitor implementation.

Human resources and capacities to deliver services

The limited capacity of MoE to formulate policy, plan and manage is a serious constraint at all levels of the sector. There are too few technically qualified people available to envisage what 'Afghanistan specific' education could and should be. As donors reduce their advocacy and technical assistance, it is vital that the commitment to institutional and professional development is sustained – including the training of women.

Centralization is hindering innovation and attempts to tailor approaches to local situations, from teachers and head-teachers right through to provincial education managers.¹⁴⁸ In addition, poor coordination between MoE and other ministries responsible for children, as well as provincial and district authorities, is a major underlying cause of weak educational outcomes. The Human Resource Development Board, established in 2010, has the potential to enable better dialogue across the education sector, but that potential has so far not been realized.

The emphasis placed on developing the Education Management Information System (EMIS) is important: collecting, managing and using education data is a vital determinant of good quality, effectiveness and efficiency. EMIS's ultimate goal must be to function as a complete, accurate and well-managed institution for tracking trends and enabling evidence-based action.

Teacher education has evolved rapidly over the past decade, from just four teacher-training colleges (TTC) in 2002, with 50 male lecturers and 450 pre-service student teachers, to 42 TTC and 80 satellites, with 1,700 lecturers and almost 65,000 student-teachers now, 40 per cent of whom are female.¹⁴⁹ To some extent, however, speed of supply and quantity has been prioritized over depth of implementation and quality. There is also a lack of information as to what graduates do on completing the programme, whether they go to a school in the area; wait for deployment to better places; or take jobs outside the system where, according to some Grade 12 girls, "the pay is better, work easier and status higher".

Of particular concern is the persistent flow-through of students from TTC to university rather than to teaching. Efforts to reform the over-academic curriculum and strengthen the emphasis on child development, learning theory and pedagogical practice have so far not been successful. A new pilot project involving the Teacher Education Department and three TTCs intend to address these problems. Once this is confirmed as viable and effective, the plan is to scale up nationally.

Problems associated with the primary and secondary curriculum include: in-service training that is insufficient in scope, frequency and quality, especially for subject teaching at secondary level. Teacher guides are difficult to interpret and late in coming and there are too many secondary subjects to be covered each year. Another issue is the extent to which the rights of children in rural and marginalized areas are being undercut by the curriculum content itself, with

decisions made in Kabul leading to teaching that is irrelevant or inappropriate. It is also necessary to address the persistent and so far largely intractable dilemma of girls especially at the secondary level, dropping out of schools that provide only male teachers – with whom girls are considered unsafe and breaching community norms.

It is generally acknowledged that teachers in Afghanistan need to be better at assessing children's readiness to learn, and at monitoring their learning progress. They should also be able to evaluate how their own performance in class affects how children learn. In addition, those expected to provide pedagogical guidance and oversight – principals and senior teachers – are not providing this support effectively.

Demand-side barriers to service utilization

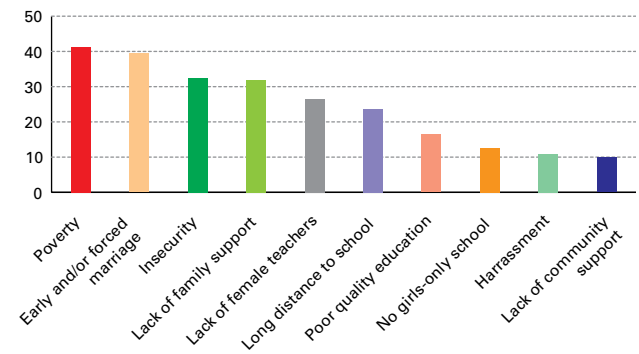
Socio-cultural norms in Afghanistan are not necessarily barriers to education. Afghan parents, as in other countries, decide if and when to send their children to school based on their perception of costs, benefits and risks. And, seen from their perspective, the decisions are generally logical.

Family poverty is one of biggest barriers to girls' access to education according to 41.2 per cent of parents, teachers and girls interviewed in one study.¹⁵⁰ Afghan parents are known to value education. Qualitative research shows they believe it has a positive impact on a child's ability to earn an income. This belief still applies, however, much more strongly to boys than to girls. The latter are generally expected to marry early and become part of their husband's family thereby denying any potential economic benefit to her own family that education might bring. The value of investing in the education of children with disabilities is also not yet fully understood by Afghan society.

Terrain and the physical location of schools influences their use. The 2011 Joint NGO Briefing Paper on Girls' Education found 23.7 per cent of girls and parents living in remote or physically treacherous areas chose not to risk lengthy walks to school due to risk of fatigue, male harassment, traffic accidents or attacks from armed opposition groups or animals. Insecurity is also a factor here: the farther a school is from immediate community oversight, the more vulnerable it is to attacks; and the less able families are to negotiate with the assailants.

Mothers' education has a direct influence on broader gender and education equality goals. When a mother has functional and life-skills literacy, it is more likely that her children, especially her daughters, will go to school. The prevalence of early marriage means that many mothers are themselves still children under the CRC and Afghan law; they have their own right to an education that is relevant, appropriate and comprehensive which should be fulfilled. Afghan men play a key role here: as husbands, fathers and brothers. They determine what girls and women can do at home and in public, whether as students or as decision-makers.

Figure 25 Key Obstacles to Girls' Education



Source: Oxfam International, 2011

The lack of sufficiently accessible and locally responsive adult literacy and non-formal education adversely affects children's participation in learning and this is expected to become worse as donor resources decline. Life and livelihood skills programmes are directly linked to improved family income and better management of household resources. Over the long term, they can also help create a pro-learning community culture and enable parents to support their children's learning.

Strategic areas for action

Two linked, overarching challenges face the education sector as the country moves through the transition. The first is to develop a better understanding of the dynamics and diversity of Afghan culture, and examine its implications for creating a national education system. The second is to support technically appropriate and locally relevant mechanisms for providing high quality education. Data suggests that both challenges are proving difficult. While demand for education is reported to be strong, the goal of firmly establishing children's right to education as a value among Afghan families has some way to go.

Specific recommendations are:

- **Ensuring that education is inclusive**

Progress towards genuinely inclusive education could be strengthened under the direction from the MoE. Among the key issues that urgently need addressing are:

Insufficient attention is paid to the needs of children with disabilities; these children are sometimes considered to be the primary responsibility of the MoPH rather than the MoE, whereas both Ministries should be taking their needs into account. As of 2005, there were 196,000 school-age children with disabilities, with only 22 per cent in school and over 75 per cent of them dropping out at the primary level.¹⁵¹ The absence of more recent data is telling in itself.

The education sector is not doing enough to cater to the needs of working children. Families struggling with poverty, food insecurity and isolation are finding the benefits of school outweighed by the costs and the need for children to contribute to household income. There should be flexible

"I feel so happy about coming to school. It gives me courage, power and hope for the future. For example, I can do this interview now whereas before I wouldn't have been able to do it."

says Farzana Tanha,
seventeen year old.



// FROM THE FIELD

Farzana Tanha is one of the top students in the school. The shy

17 year old dreams of one day becoming a doctor. "I feel so happy about coming to school. It's giving me courage, power

and hope for the future. For example, I can do this interview now whereas before I wouldn't have been able to do it."

alternatives that would allow working children to continue learning as part of the national education system.

Children from minority ethnic communities are struggling to gain access to education. While Kuchi children are doing somewhat better in specially tailored and mobile schools, Jogi and Chori Frosh children are among the most marginalized groups in terms of access to primary and secondary education.

The education sector needs to do more to track children who drop out of school so as to better understand how to meet their needs.

- **Stopping corporal punishment**

Corporal punishment is still widely practiced in schools, despite being prohibited under the 2008 Education Act. Teachers are not given sufficient training in positive forms of discipline and little action is being taken to protect children from routine physical abuse within schools, which should ideally represent a place of joyful learning and safety.

- **Engaging more with communities**

Too often, parents, students and teachers look to government and NGOs to address their needs, rather than seeing themselves as rights-upholders advocating for those rights to be fulfilled. This suggests there is a need for more nuanced expectations and more differentiated, incremental and interactive approaches by MoE and partners in engaging communities. Attempting to implement a Western, centralized and heavily bureaucratic education system all over Afghanistan may be inherently inappropriate and finally untenable in a country still in serious conflict within itself, with underlying cultures, traditional institutions and socio-geographic realities that are significantly different in many ways.

- **Making education more local**

Education is at its most effective when it is local – where it is a function of users, not just suppliers. A national system may provide an enabling environment, but ultimately Education for All will only be achieved when children and families are put at the centre of it, and the system understands and responds to what and how they need, and want to learn. This is especially critical in Afghanistan, where both the State and the education sector are weak, and regions in the country are independent of the centre. It is, of course, necessary to ensure that all children have access to a core set of learning principles (child-centred, responsive, equitable) and goals (literacy, numeracy, critical thinking). However, allowing more local interpretation may not only be the most realistic, but also the best option.

The reduction of external resources may actually foster this process. Even more vital in bringing about a refocus may be the mounting insecurity in many provinces, where there is growing evidence that peaceful, equitable and sustainable negotiations on education happen only when they are based within affected communities. The ‘youth bulge’ is another indication that creating more diversity of education supply and genuinely decentralized arrangements means more and better investments in children's future.

- **Working with civil society**

Co-ordination with local mechanisms and groups is gradually leading to involvement of Afghan civil society organizations in government decision-making. However, creating new institutions and re-engineering existing ones to work in different ways are long-term and labour-intensive processes. Training of civil society organizations will need to help them clarify their own vision for children and learning before trying to commit them to the CRC and EFA goals.

- **Thinking more creatively**

In responding to the pressures for change, the education sector needs to consider how to address poor performance at all levels and to enhance capacity to reach the most vulnerable children.

There is a tendency to equate inputs with outcomes, that is, actions in support of change with actual change. The education sector also often favours dramatic large-scale targets over the more mundane stages of consolidation and institutionalization, which are gradual and long-term but may well be more effective.

Despite the progress in providing CBE classes, sufficient attention is still not being paid to developing flexibility in providing education that will be essential if the EFA goal is to be reached. There needs to be much better co-ordination and trust between the constituents of the education sector in order to make this possible.

The education sector needs to be prepared to think outside the box in assessing problems and testing options. The GPE is a promising instance of moving toward expanding and reinforcing multiple pathways to education and this should be built upon.

- **Making schools child-friendly**

A child-friendly school (CFS) captures the full spectrum of children's right to education. Whether formal or CBE, such schools are responsible for taking the first steps in reaching out to missing and vulnerable children. This task is shared with families, communities and others responsible for children in some way. And CFS support the fundamental conditions of child-centred learning. Five dimensions characterize a child-friendly school: inclusion and gender equality; effective teaching and learning; healthy, safe and protective behaviour; participation of children, parents and community; and a readiness to make the case for a CFS-enabling policy and institutional environment. Efforts to advance much of this are beginning through UNICEF-supported and NGO programmes, but the last two dimensions in particular warrant much more attention.



Water, Sanitation and Hygiene

Status and trends

Drinking Water

Drinking water coverage in Afghanistan has increased dramatically over the past decade from 22 per cent in 2000 to 64 per cent in 2012 (urban 90 per cent and rural 56 per cent). 14.5 million people gained access to an improved drinking water source since 2000. Many have done so through rehabilitation of existing sources and many have newly gained access. Only 10 per cent of the population (28 per cent in urban areas and 4 per cent in rural areas) enjoys the benefits of a piped drinking water supply on premises. Roughly, 24 per cent of the population relies on boreholes

equipped with hand pumps, motorized or solar pumps, 17 per cent use improved dug wells called Kariaz, 10 per cent use public taps and 3 per cent use protected springs. 16 per cent of the population still relies on surface water from rivers and streams. In 2012, 10.7 million people (36 per cent) did not have access to an improved drinking water source – down from 16.0 million in 2000. Over nine out of ten people without an improved drinking water source live in rural areas, but seasonal migration to informal settlements in peri-urban areas means that in winter-time there is an increase in the number of people without an improved drinking water source in urban areas.

Table 6 Access to Improved Water and Sanitation since 1990

Coverage (%)	2000	2012	MDG Target	Population without access
National drinking water	22	64	50	10.7 million
Urban drinking water	36	90	-	0.7 million
Rural drinking water	18	56	-	10.0 million
National sanitation	23	29	56	21.2 million
Urban sanitation	32	47	-	3.8 million
Rural sanitation	21	23	-	17.4 million

Source: WHO/UNICEF, *Joint Monitoring Programme. Progress on Sanitation and Drinking Water: 2013 Update*, 2013.

A person from the richest 20 per cent of the Afghan population is almost three times more likely to use an improved drinking water source than a person from the poorest 20 per cent of society.

Drinking water coverage is lowest in the Central Highlands region (25 per cent) followed by the North-east (44 per cent) and North (45 per cent). Coverage is highest in the Central region (69 per cent) and South-east (67 per cent)

A large scale survey among over 20,000 water points showed that on average one-third of hand pumps are out of order in Afghanistan at any given time. Community management of hand pump operation and maintenance which is the preferred model seems to work well for the majority of pumps, but another operation and maintenance modality will have to be found for the one-third that remain broken. A poor spare part supply chain and limited qualified operators seem to be the largest bottlenecks.

Several areas in Afghanistan are plagued by high levels of arsenic or fluoride and the situation of about half of the country is currently mapped. Security concerns prevent further drinking water quality mapping of the country. The scale of the arsenic and fluoride problem is limited and highly localized. Wells where too high levels of arsenic or fluoride are encountered are often closed and the public is encouraged to use other sources which are not contaminated. Microbiological contamination is widespread especially in high-density areas, so not all drinking water from improved sources can be considered safe. Household level bio sand-filters are increasingly promoted as household water treatment options.

Sanitation

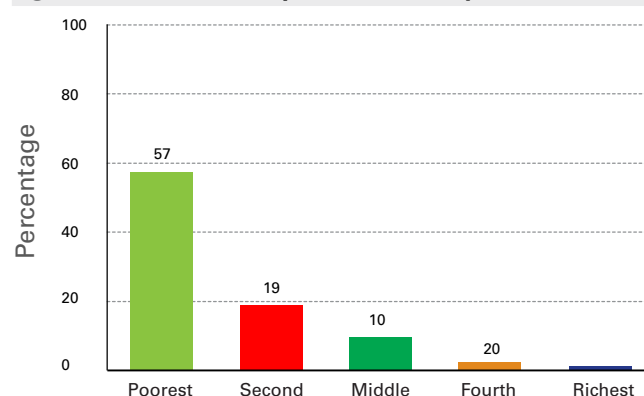
Improved sanitation coverage in Afghanistan has only increased by 6 percentage points from 23 per cent in 2000 to 29 per cent in 2012. (urban 47 per cent and rural 23 per cent). The number of people without an improved sanitation facility in fact increased by 5.4 million from 15.8 million in 2000 to 21.2 million in 2012. Yet most of these practice fixed-place defecation in traditional latrines and toilets that are not considered hygienic as they do not adequately separate human waste from human contact. The open defecation prevalence dropped significantly from 28 per cent in 2000 to 15 per cent in 2012. The number of people practicing open defecation dropped by 1.1 million over the same period from 5.7 million to 4.6 million.

Open defecation is most prevalent in the Central Highlands

region where about half the population does not use any toilet, followed by the West (31 per cent) and the East (24 per cent). Open defecation is least in the Central region (1 per cent) and North-east (3 per cent).

A person from the richest 20 per cent of the Afghan population is almost eight times more likely to use an improved sanitation facility than a person from the poorest 20 per cent of society.

Figure 27 Prevalence of Open Defecation by Wealth Quintile

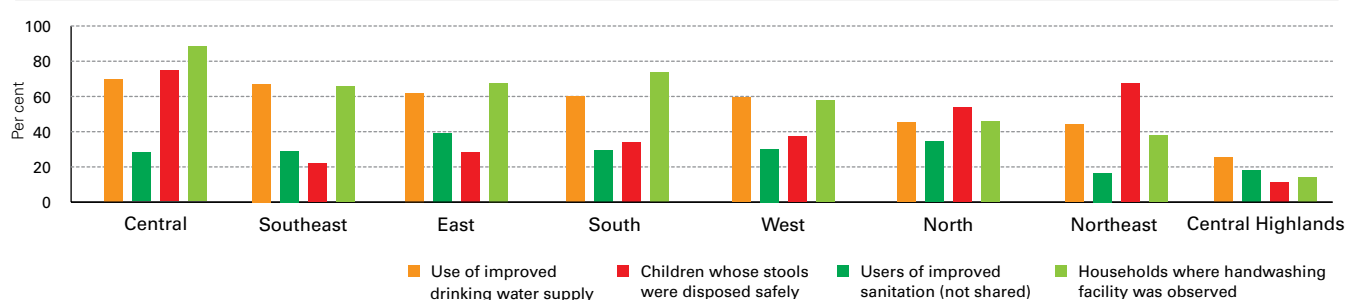


A detailed UNICEF study assessed WASH vulnerabilities across Afghanistan.¹⁶³ Two districts in each province were analysed, comparing a number of WASH-related factors such as open defecation, access to improved drinking water sources, and the existence of awareness campaigns. A range of compounding factors were also considered: accessibility, the security situation and the availability of hospitals and health centres. These comparisons across all villages utilized both secondary data and key stakeholder opinions and were supported by focus group discussions in two villages in each district. The most vulnerable provinces overall were Baghlan, Faryab, Helmand, Kandahar, Kunar, Laghman and Logar. Other provinces ranked highly for particular vulnerabilities.

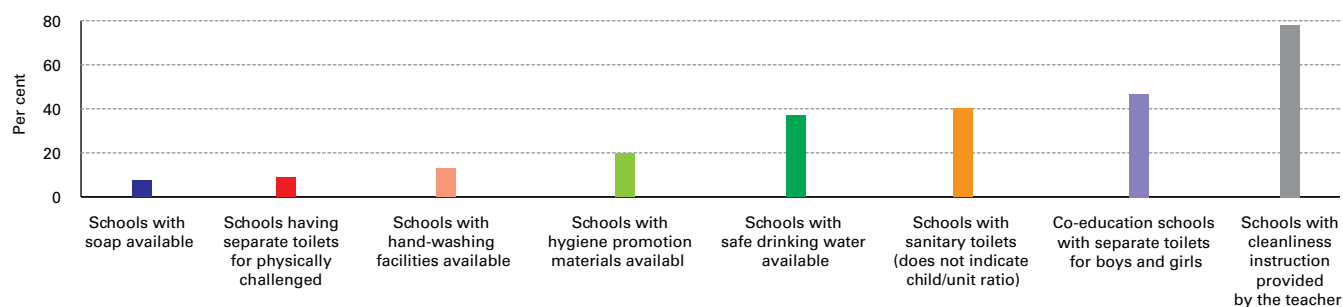
WASH in schools

Considerable progress has been made in the area of WASH in schools over the past few years. The Ministry of Education now has standard latrine designs for use in schools. Moreover, senior management in the education sector now have an increased understanding of WASH's importance for schools across Afghanistan. A 'Call to Action' was undertaken in 2010, for which a useful practical document on good WASH practices in schools was prepared.¹⁶⁴ Many challenges still exist, however, including limited funding compared to the cost of operating and maintaining adequate facilities in schools.

Figure 26 Water, Sanitation and Hygiene Practices by Region



Source: MICS 2010/11

Figure 28 School WASH in 9,000 Schools Across 24 Provinces

Source: Manzoor, Asim, *Final Analysis Report on WASH Data in Schools in Afghanistan*, Organizational Development Consultants International and UNICEF, 2011.

WASH is already integrated to some degree into various elements of the work of the health sector and various inter-sectoral dimensions of nutrition. There is, however, a critical need to reflect on how well this has been integrated, and where it can be strengthened for mutual benefit. When WASH practices improve, the health of the population improves, fewer children under five years of age are malnourished and fewer children die and into all elements related to health promotion, nutrition and the training of staff.

Critical WASH practices, particularly hand-washing with soap and use of a toilet, are integrated into all national campaigns, including those on de-worming, Vitamin A distribution, integrated management of childhood illnesses, mother and child clinics, the training of community health workers, traditional birth attendants and others. Particular gaps have been identified in basic health centres,¹⁶⁵ though even centres with comprehensive emergency neonatal and obstetric care have some deficiencies.¹⁶⁶ Indicators for WASH in health facilities have been included in the HMIS, but need reviewing for improvements to be made.

Key strategies

WASH is part of a wider sector covering other aspects of water such as trans-boundary water, irrigation, water for energy and integrated water resources management. The water sector is co-ordinated by the Supreme Council for Water Affairs Management, which is chaired by the Vice President of Afghanistan.¹⁶⁷ There appears to be no reporting link between The MRRD heads the monthly Water Sector Group (WSG) a co-ordinating mechanism for the WASH sector.

The Urban WSS Policy¹⁶⁸ has considered the issue of affordability for low-income communities, but is weak on gender. Meanwhile, an effort has been made to integrate gender concerns into the Rural WASH Policy and some useful practical guidance is included in the implementation manual.¹⁶⁹ However, the translation of this into practice still poses many challenges, particularly where communities are resistant. The lack of women working in the sector is not helpful in this respect.¹⁷⁰

Some of its key observations are:

- The rural WASH implementation manual is a comprehensive document that provides useful guidance for the sector.¹⁷¹ A few areas could be strengthened, including guidance on involving people who are differently able and simple adaptations in WASH facilities for people with limited mobility. A much clearer strategy should also be developed on

how to upgrade the traditional latrine to an 'improved' one.

- There are draft strategies on sanitation¹⁷² and on hygiene promotion¹⁷³, both of which need to be completed. The combination of approaches being proposed including community-led total sanitation and sanitation marketing that involves private sector participation is aligned with current best practice.

- The urban water supply and sanitation policy¹⁷⁴ does not cover on-site sanitation or hygiene promotion. This leaves a significant gap in the sector's policies, as most people living in urban areas use on-site sanitation (latrines of various types, some with vaults, and others with septic tanks).

- Clearer policies or strategies are needed on water quality, school WASH, the operation and maintenance of water points and sanitation facilities, and on how to involve the private sector. There should also be a sector-wide assessment of and plan for capacity development.

- A specific strategy should be developed on how to increase the participation of women and people from marginalized groups.

Key programme approaches

The WASH sector is working towards establishing a sector-wide approach and moving away from project-based funding. As yet, donors do not contribute to an overall fund based on a single strategy, but the sector has improved coherence in a number of ways.

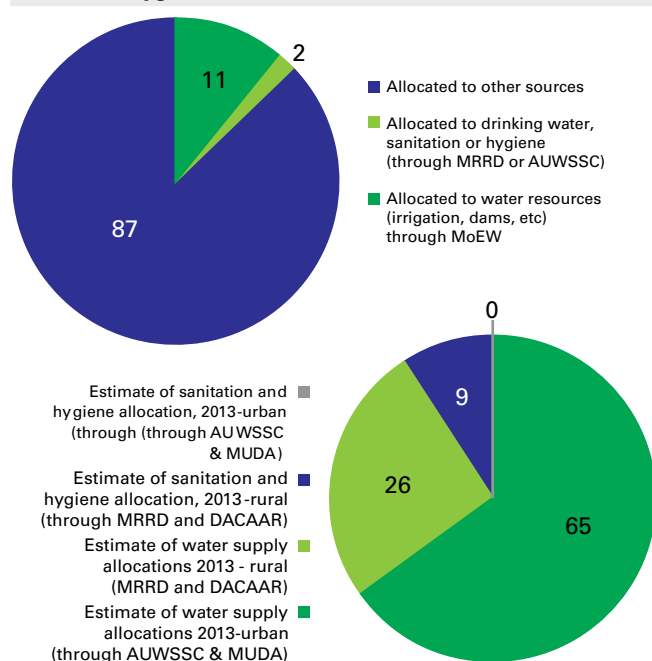
Efforts have also been made to strengthen co-ordination over the past few years. The WSG provides the main co-ordination forum for the sector, bringing together rural and urban actors, government, civil society organizations, the UN and both bilateral and multilateral development partners. There is also a WASH Cluster mechanism co-ordinating humanitarian action, which is co-chaired by MRRD and development partners specialized in WASH. The plan is to move towards one integrated co-ordination mechanism¹⁷⁵ which should greatly improve efficiency and coherence, and serve to build resilience and disaster risk reduction into all WASH projects. However, responsibilities of the key ministries in the sector still needs greater clarification, particularly around cross-cutting issues such as sanitation, hygiene, water quality and school WASH.

There is an urgent need to look at whether rural and urban approaches are coherent – and to consider if a single 'Afghanistan WASH Policy' could be developed instead of separate policies for rural and urban areas. In particular, the sector needs to ensure that sanitation and hygiene effectively

cover all urban areas, particularly including low-income neighbourhoods, informal settlements and small towns. A detailed implementation manual has been developed for rural WASH providing guidance on most elements of the sector's work, including water-point infrastructure, operation and maintenance, sanitation approaches, and gender. The rural WASH sector is currently in the process of developing a sector-wide management information system,¹⁷⁶ which will be managed by the MRRD. Some thought will be needed on possible linkages with the data collection managed by other ministries. Monitoring and the use of disaggregated data are also areas that require strengthening.

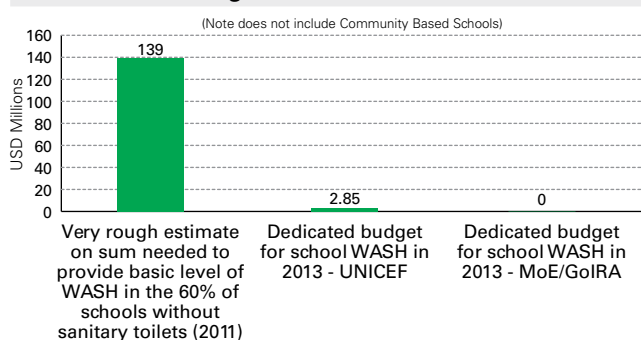
Budget allocations

Figure 29 Funds to WASH and Allocation of Sector Finances between Water and Sanitation and Hygiene



Source: UNICEF and MoE

Figure 30 Budget Requirements for School WASH and 2013 Budget



Source: UNICEF and MoE

It is clear that current budget allocations (from all sources) fall far short of meeting the WASH needs of Afghans (see figures 26 and 27).¹⁷⁷ Sanitation and hygiene in particular are chronically underfunded, receiving only 9 per cent of the total national budget.

The lack of any budget allocated to urban sanitation and hygiene is extremely worrying. Some funds may be allocated through the municipal councils, but much of the work undertaken in urban areas on sanitation and hygiene is funded by the private sector, civil society organizations and the International Federation of the Red Cross and Red Crescent Societies (IFRC).

The limited budget allocation for school WASH is also a matter for concern, given the likely impact on girls, and also the missed opportunity to instil good hygiene practices in the next generation, who will become mothers and fathers in the future.

The Government's allocation from its discretionary budget is only 2 per cent, compared with the 11 per cent allocated for wider water resources (such as dams and irrigation). This indicates how WASH is getting 'lost' within the wider water resources sector.

Considering the significant impact that water, sanitation and hygiene have on under-five mortality, the quality of education and a range of other indicators, it is clear that the low priority given to the sector means that key rights of children and women will remain unfulfilled.

Human resources and capacities to deliver services

The WASH sector has undertaken two key capacity assessments in the past eight years: one focusing on the roles and responsibilities of institutions involved in urban water supply and sewerage,¹⁷⁸ the other on rural WASH.¹⁷⁹ The sector also undertook a self-assessment of its own capacities as part of the global monitoring process for water and sanitation.¹⁸⁰

The sector already has a range of capacities, reflected in the achievement of the MDG water targets. There is, however, a need to undertake a more detailed capacity assessment of the sector that brings together the needs from all elements and levels. This should also include evaluating higher education institutions, to establish whether they are providing the sector with an appropriate supply of professionals with the right skills.

Among the current capacity development needs in the sector are:

- **Enabling environment.** The coherence and linkage of the various co-ordination mechanisms should be strengthened. WASH needs greater political support and increased resources, which means raising its profile within the 'Water Sector', the wider development arena and, in particular, with the leadership of the health and education sectors. There is a welcome plan to establish a regulatory authority for urban water supply and sewerage.¹⁸¹

- **Institutional capacities.** Moving from a project-based to a sector-wide approach is vital. Monitoring and information systems should be strengthened, as should the system for operation and maintenance of WASH facilities. Clearer criteria

for selection and targeting of projects would help overcome political interference in decision-making and produce more equitable allocation of resources.

- Human capacities. Staff numbers at sub-national level in the three key ministries must increase, and existing staff need access to transport, communication equipment and funds that will allow them to do their jobs effectively.

- Recruiting more women. Recent analysis of the gender aspects of the National Solidarity Programme provides a useful picture of the multiple challenges that women face.¹⁸² These are probably similar in the WASH sector, which already attracts more men than women due to the technical nature of parts of the work. If the rights of children and women are to be met, the sector needs to significantly strengthen its efforts to attract and retain women.

Demand-side barriers to service utilization

Hygiene behaviour: the promotion of good practice

Knowledge and practice of good hand-washing behaviour is still low across Afghanistan, although most people report washing their hands just before eating (different studies estimate this at between 40 per cent and 80 per cent).¹⁸³ This is the most critical intervention for preventing ingestion of pathogens that can lead to infections and illnesses. Bathing tends to be irregular, commonly between intervals of a week to a fortnight.¹⁸⁴

It is common for women to believe that they should not bathe or wash their genitals during the menstrual period.¹⁸⁵ Some women also believe that they should not bathe for the first 20 days after delivery of a child due to fears about being rendered infertile or becoming sick.¹⁸⁶ Others believe they should not wash a newborn child for fear the baby might be affected by the 'evil eye'.¹⁸⁷ All these practices have significant implications for both hygiene and dignity – and also for health. A new communication strategy is being prepared for hygiene promotion in both communities and schools.

Measuring access to sanitation in Afghanistan is complicated, mainly because of the form of traditional latrine commonly used: a raised single vault latrine. Faeces are often stored in the vault either with no door or an open door, and then spread on the fields before it has fully decomposed. This means the latrine does not meet the required criteria of hygienically separating human excreta from human contact. Spreading fresh faeces on the fields has the same effect as open defecation. Pathogens are in the open environment and can be washed into water sources or picked up by those working or playing in the fields.

Challenges for children and teachers with disabilities

If sanitation facilities are not accessible to children with disabilities (with ramps, seats and hand-rails), they have to crawl across or sit on the floor in a latrine, which poses issues of both dignity and health. In such circumstances there is a much greater risk of contamination by faeces in latrines with

poor hygienic conditions. Managing menses while in school is particularly difficult for girls with disabilities.

The sector needs to strengthen its work to ensure that people with disabilities are pro-actively included in all activities. People with disabilities face multiple barriers to their involvement in WASH programmes and to access facilities.¹⁸⁸ Sanitation technicians must be taught how to adapt low-cost household latrines for people with limited mobility.

Gender issues

Traditional beliefs about gender relations mean that women and men outside of the family cannot always sit together and speak to each other. This poses significant challenges for the involvement of women in decision-making processes at the community and household levels. It also limits the involvement of women more generally, particularly when there are no women in the WASH team.

Traditional cultural attitudes to gender have significant implications on how the sector works, challenging its ability to involve women in programmes and services. The National Solidarity Programme has provided a modest but important example of how a nationally sanctioned approach of involving women in decision-making has created opportunities for some women and men to work together.¹⁸⁹

Inadequate WASH can inhibit girls' school attendance, particularly adolescent girls who are menstruating. Some ground-breaking research on menstrual hygiene – in global as well as national terms – was undertaken in 2010 in Kabul and Parwan provinces.¹⁹⁰ This identified the need to provide not just girls but also teachers with information on good practices related to menstruation. The study found that 29 per cent of girls miss time in school due to their menses, over 70 per cent do not shower during their menstrual period, and 50 per cent were unaware of menstruation until it started. Similar issues have been highlighted in studies in other parts of Afghanistan.¹⁹¹

Other demand-side issues

Conflicts over water tend to increase during periods of drought,¹⁹² and children risk harassment when collecting water. The poor choice of locations for water points, often in front of mosques or other places where men congregate, can lead women to walk longer distances to collect water from elsewhere, sometimes from unsafe sources.

Members of Kuchi communities tend to have less access to improved water sources and to improved sanitation. They are also likely to pay more for water, and have to walk longer distances to reach it.¹⁹³ Members of other minority groups such as the Jogi and Chori Frosh face particular challenges and risk of harassment when they have to collect water far away from their housing area due to their being marginalized in the society.¹⁹⁴

The WASH situation for people in particularly vulnerable situations requires further investigation by the sector. Women in prisons, for example, some of whom are seeking

refuge from abusive home environments,¹⁹⁵ may have trouble managing their menstruation.¹⁹⁶ 'Night soil' collectors¹⁹⁷ in urban environments and children living or working on the street¹⁹⁸ face particular challenges in ensuring good hygiene.

A challenge of a different sort emerges from people's sense of dependency – expecting an outside organization to repair their broken water points. This displays a lack of confidence in their ability to solve their own problems.

Strategic areas for action

- **Increased communication, awareness-raising and advocacy** must ensure that the importance of good WASH practices in strengthening the rights of children and women are understood. It should also ensure that WASH becomes a much higher development priority with increased financial resources. This will involve advocacy not just with policy-makers but also with the leadership of the education and health sectors. It will also mean improving the sector's analysis of the investments required and strengthening accountability systems. Linking up with global WASH sector networking and advocacy events and forums may also help.

- The coherence of the WASH sector needs to be improved by **strengthening co-ordination, and moving away from project-based implementation to establish a sector-wide approach**. There must be stronger linkages between urban and rural sectors, and improved data and knowledge management systems.

- **WASH policies, strategies and plans need to be updated and strengthened** – and translated into local languages. Training in key policies and practices needs to be offered at the provincial and district levels. Regulation and enforcement needs to be stronger. A strategic plan for the sector should be developed and an annual review process established.

- **Existing programmes need to be scaled up** – especially those on sanitation, hygiene communication, school WASH, water quality, and operation and maintenance. Improved integration into programmes associated with the health and education sectors is vital.

- **The gender, equity, inclusion and protection aspects of the sector's work must be strengthened** and strategies developed to recruit and support more women and people from minority groups at all levels.

- Increased collaboration is needed with the education sector to **ensure that SchoolWASH is prioritized, properly resourced and fully integrated** into all elements of its work. WASH (including menstrual hygiene) needs to be included in the curriculum and in teacher training. Data and monitoring of WASH in schools needs to be improved in the EMIS.

- **Good WASH practices need to be effectively integrated into all elements of the health and nutrition sector's work**, not least among them to improve prevention of WASH-related morbidity and mortality of children under-

five years of age. WASH promotion must be incorporated into all key national health and nutrition interventions and campaigns. WASH should also be included in the training of all professionals in the sector – and of community health workers and traditional birth attendants too. WASH provision in health facilities needs to be improved, especially at the district level, and the indicators on this in the Health Management Information System reviewed.

- **There needs to be greater awareness of the importance of drinking water quality**, and systems developed to monitor and improve it. Charges should be levied for water-quality tests in order to improve their sustainability.

- The national **systems for maintaining water points and monitoring their functionality require strengthening**. New measures for disaster risk reduction are also necessary and should be incorporated into WASH programmes implemented in community, school and health facility levels.

- **Sector capacities need to be built up at all levels**. This will involve a sector-wide capacity development plan, improved human resources management and logistical capacities, and a review of education and training opportunities. Building capacity will also involve strategically identifying, engaging with, and developing relevant areas of the private sector, especially in relation to new community-friendly technologies that provide access to people with disabilities.



Conclusion and Recommendations

Improving education and health care services and expanding access to clean, safe water has been fairly successful in Afghanistan. Achievements in primary school enrolment and in child and maternal mortality at the national level have, however, masked stark disparities that exist between provinces, sex, and urban and rural areas. Inequality and discrimination between groups and locations can be partly attributed to the country's legacy of conflict which has destroyed infrastructure, exacerbated poverty, frayed the country's social fabric, and made families more vulnerable to natural disasters. Conflict and insecurity have also created barriers for NGOs, development partners and civil servants to access certain areas and provide services. There are also concerns of imbalance in the development agenda with certain sectors, such as health and education, receiving more attention than others, like protection or sanitation.

This first decade of the twenty-first century in Afghanistan was focused on establishing government systems. Overall, the building of these systems has been successful, though not without some difficulties. While some sectors, like health and education, have benefited to some extent, others like protection or sanitation have remained grossly underfunded. While several sectoral policies provide a framework for the delivery of quality services, their implementation continues to fall short due to resource and capacity constraints. Often, the targets and plans are over-ambitious. Afghanistan has been, and remains, the highest recipient of ODA in the world with significant funds directed to strengthening security and delivering social services. Although funding may not be sufficient to meet ambitious targets, it is not the only reason for recent stagnation in progress on key development indicators and persisting disparities among groups. The greater concerns are around effective design and implementation, and efficient strategies to ensure equity in services. Another concern is promoting the 'less visible' child rights related to protection, nutrition, and sanitation. To ensure these sectors have greater 'visibility' in the national agenda requires a stronger focus and commitment to child rights.

There are also serious concerns about the sustainability of these programmes given the vast majority of funding is "off-budget", provided by donors. Funding for development projects continues to be donor driven, with little appreciation for local priorities or circumstances. The poor and most vulnerable will not benefit unless budgets are allocated and executed at sufficient levels, prioritizing essential services to reach the most marginalized communities.

A peaceful future for Afghanistan cannot be envisaged unless deprivations are reduced and disparities between gender, geographic locations and urban-rural areas are addressed. Providing quality services for all children, particularly the most vulnerable and deprived among them, is fundamental



to strengthening effective governance systems. Much depends on the connection between data collection and analysis, planning, budgeting and monitoring, and staff capacity to make the system work. Equally important is donor confidence in these systems. Lack of confidence, perceptions of corruption and the need to demonstrate quick results, has led many donors to create and support parallel systems. Bypassing government structures has meant that capacity has remained low. Mechanisms for accountability and oversight, through civil society watch dogs and the parliament are also weak.


Economic growth and security have deservedly remained on top of the Government's agenda. However, over-emphasis on these two issues has meant that children's rights and special needs are not prioritized in the national agenda. Accounting for more than half of its population, Afghans under the age of 18 are the country's best hope for the future. These children will be the workforce and the main architects of the country's future development. Neglecting their concerns now will result in failure to make real progress in the future. The foundation laid by the Transitional Government, and expanded in the recent past, has resulted in major advances for children and women. Over the next ten years of the Transformation Decade, it is imperative that the political will and the commitment of development partners are galvanized. This will be necessary to break the cycle of poverty, conflict and inequality that have created insurmountable obstacles for so many children, adolescents, and families. It is critical that during the next phase of Afghanistan's future, the steps that have been taken so far are translated into meaningful and sustainable change.

The following are overarching recommendations for all actors and stakeholders involved in or supporting the education, health, nutrition, protection and development of women and children in Afghanistan:

1. Elaborate social policies and legal frameworks from a rights perspective.

The Constitution of Afghanistan (2004) provides a framework for achieving protection of human rights. However, there is little recognition of the special requirements of children and the unique rights afforded to them. Continuing delays in drafting and enactment of the comprehensive Child Act is a cause for worry. The Act could supersede and harmonize the fragmented and inconsistent laws affecting children, including laws derived from religion or tradition. The current disjointed legal framework is such that the best interests of the child often remain unfulfilled. The Child Act would go a long way in aligning national legal frameworks to the Convention on the Rights of the Child and its optional protocols, setting the stage for realizing children's rights. The Child Act's public presentation would provide an opportunity to raise the profile of children on the national agenda. It will help to advocate with legislators that all future legislation, policies and budgets are assessed from the perspective of children's well-being. Importantly, it could elevate equity concerns and rights of poor, deprived children.

To ensure that services reach the most vulnerable and deprived children, it is essential that policies, programmes and legal frameworks are based on sound data and analytic work. Such information is especially needed to



guide discussions on where and how to allocate resources, both financial and human. Knowledge of the implications of stronger rights focused policies and programmes, and how they can consolidate programmes for children will be important.

2. Use citizenship to foster active civil society and as a tool for effective policy dialogue.

Children and their families have legally endowed rights both through international human rights conventions and domestic legal frameworks. Rather than being viewed as recipients or beneficiaries of services there needs to be a shift in viewing children and families as rights holders, and to situate the concept of citizenship within development strategies. Children – especially those aged 10-18 years, and their families, particularly the poor and marginalized – should be involved as active participants in the development process. This calls for the opening up of a common space for adolescents, children, parents, and caregivers to express their views and preferences and participate in decision-making and monitoring activities. It is particularly important to involve adolescent girls and women in order to initiate real, positive change. There also needs to be additional outreach targeting boys and men. Further, the religious leaders can teach the importance of advancing the rights of girls and women. Outreach targeting boys and men needs to be strengthened, underscoring the importance of building skills of girls and women can help them to actively and meaningfully participate in the development process.

There is no consensus on what is ‘in the best interest of the child’. Oftentimes, what is truly best for a child is compromised by economic circumstances, conflict or conformity to social norms. There is a need for greater understanding and advocacy of what constitutes ‘the best interest of a child’ from a rights perspective, from the family level all the way to senior government officials at the national level. There are certain issues, particularly protection issues within the family, which are viewed as private, domestic issues over which the Government has no basis to interfere. There is a need for greater awareness of the obligations of various levels of duty-bearers involved in realizing the rights of children – from families, to institutional caregivers, to parliamentarians and government officials.

A key challenge for organizations working for children is to engage the public and political leaders in an effective dialogue to explain state, community and parental obligations towards children. A stronger advocacy platform at all levels is required to ensure that children and thus the future of Afghanistan remain as a priority on the national development agenda. Champions of children need to be identified and supported so that children’s issues are duly represented in key policy, planning and budgeting processes. There is also a critical need to promote effective participation of children and adolescents in the decision-making processes at the family, community, provincial and national levels.

3. Take forward achievements and lessons from community-level and community-led approaches to health, nutrition, education, water and sanitation, and protection.

There have been several positive experiences in reaching the hard-to-

reach people through community-based interventions. Community-based schools and mobile clinics have been instrumental in improving outcomes for children in education and health. These lessons clearly demonstrate a need to work with communities to identify innovative solutions to address local development issues. The education and health programmes have demonstrated that through collaborative partnerships between donors, government and non-government organizations even the most marginalized can be reached.

Understanding the possibilities and benefits of a strong, decentralized, community managed programme for children is important to prioritize children in local planning processes. It is also essential to explore innovative approaches in recruiting, training and supporting locally based personnel in underserved rural communities.

4. Sustain fiscal commitment to social services

In the face of reduced international aid and shrinking revenues the focus should be on the mounting deficit of opportunity rather than the persistent fiscal imbalance. The threat to Afghanistan's future stability and reconciliation is rooted in the rising inequality between provinces, between the rich and the poor and between urban and rural communities. The inability of young people to realize their potential and have their future secured and protected will disenfranchise a generation of Afghans, exacerbating tensions and stifling economic development. Safeguarding funding to the social sector – including education, health, nutrition, child protection and water, sanitation, and hygiene – as well as bolstering social protection systems that respond to vulnerabilities of children and women is the best hope for a prosperous and peaceful Afghanistan. The most promising avenue is to create sustainable economic growth and focus on improving human capital. By creating healthier, well-educated citizens the country will be better positioned to create jobs and opportunities.



Annexes

Annex 1 Progress towards the MGDs

Goals and Targets	Indicators	Data		Trend
		2007/08	2011/12	
MDG1: Eradicate extreme poverty and hunger T1.C: Halve, between 1990 and 2015, the proportion of people who suffer from hunger	Proportion of population living under the national poverty line	36%	37%	No change
Goal 2: Achieve universal primary education T2A: Target 2.A: Ensure that, by 2015, children everywhere, boys and girls alike, will be able to complete a full course of primary schooling	Primary net attendance rate*	52% (T) 60% (B) 42% (G)	57% (T) 64% (B) 48% (G)	Increased Increased Increased
Goal 3: Promote gender equality and empower women T3A: Eliminate gender disparity in primary and secondary education, preferably by 2005, and in all levels of education no later than 2015	Ratios of girls to boys in primary, secondary and tertiary education	0.69 (P) 0.49 (S) 0.28 (T)	0.74 (P) 0.53 (S) 0.42 (T)	Increased No change Increased
Goal 4: Reduce child mortality T4A: Reduce by two-thirds, between 1990 and 2015, the under-five mortality rate	Under-five mortality rate**	134 per 1,000 live births (2000)	99 per 1,000 live births (2012)	Decreased
	Proportion of 1 year-old children immunized against measles	56%	56% ****	No change
Goal 5: Improve maternal health T5B: Achieve, by 2015, universal access to reproductive health	Maternal mortality ratio***	1000 per 100,000 live births (2000)	460 per 100,000 live births (2010)	Decreased
	Proportion of births attended by skilled health personnel	24%	40%	Increased
Goal 6: Combat HIV/AIDS, malaria and other diseases T6A: Have halted by 2015 and begun to reverse the spread of HIV/AIDS	Proportion of population aged 15-24 years with comprehensive correct knowledge of HIV/AIDS	—	—	—
Goal 7: Ensure environmental sustainability T7C: Halve, by 2015, the proportion of people without sustainable access to safe drinking water and basic sanitation	Proportion of population using an improved drinking water source	22%	61%	Increased
	Proportion of population using an improved sanitation facility*****	23% (2000)	28% (2011)	Increased

Sources of data:

- National Risk and Vulnerable Assessment (NRVA) 2007/08 and 2011/12

* An alternative indicator is primary net enrolment rate

** UNICEF. Levels and Trends in Child Mortality: Report 2013 Estimates Developed by the UN IGME. 2013

*** WHO. Trends in Maternal Mortality 1990 to 2010: WHO, UNICEF, UNFPA and The World Bank Estimates. 2012

**** Afghanistan Multiple Indicator Cluster Survey 2010/2011

***** WHO/UNICEF Joint Monitoring Programme (JMP). Progress on Sanitation and Drinking Water: 2013 Update. 2013

(T): Total, (B): Boys, (G): Girls

Annex 2 Trends on Key MDG Monitoring Indicators By Region

Region	Net primary attendance			Ratios of girls to boys in primary education			Proportion of 1 year-old children immunized against measles			Proportion of births attended by skilled health personnel			Proportion of population using an improved drinking water source		
	Estimate		Trend	Estimate		Trend	Estimate		Trend	Estimate		Trend	Estimate		Trend
	2007/2008	2011/2012		2007/2008	2011/2012		2007/2008	2010/2011*		2007/2008	2011/2012		2007/2008	2011/2012	
Central	65.9	76.2	increased	0.64	0.80	increased	71.0	70.4	no change	51.5	63.6	increased	38.5	62.6	increased
Central Highland	69.4	82.9	increased	0.84	0.92	increased	33.8	53.8	increased	6.9	24.0	increased	13.5	19.8	no change
East	54.7	62.4	increased	0.67	0.70	no change	66.0	59.6	no change	24.2	40.5	increased	29.0	38.2	increased
North	54.7	72.1	increased	0.78	0.81	increased	62.0	49.9	decreased	17.1	34.6	increased	26.0	40.6	increased
North East	62.7	61.5	no change	0.82	0.80	no change	53.3	62.0	increased	13.8	16.8	no change	21.2	43.4	increased
South	10.9	19.1	increased	0.46	0.57	no change	35.2	19.4	decreased	7.0	24.9	increased	22.1	27.8	no change
South East	46.6	59.3	increased	0.40	0.50	increased	61.9	57.7	no change	14.7	41.4	increased	24.4	45.3	increased
West	49.3	61.3	increased	0.79	0.89	no change	39.5	50.2	increased	13.6	21.5	increased	20.3	41.8	increased

Sources of data:
 NRVA 2007/08 and NRVA 2011/12
 *MICS 2010/11

Annex 3 Child Poverty Indices: By Province based on NRVA 2007/2008

Province	Child Development				Reproductive Health				Child Nutrition			Environment				Child Health		
	Cluster	Not deprived	Deprived		Cluster	Not deprived	Deprived		Cluster	Not deprived	Deprived	Cluster	Not deprived	Deprived		Cluster	Passed NP	Failed P
			MD	SD			P	SP			D			MD	SD			
Kabul	3	56.8	39.6	3.6	3	52.6	28	19.3	3	82.2	17.8	3	8.2	52.2	39.6	2	26.4	73.6
Kapisa	2	36.2	57.7	6.1	2	5.3	30	64.7	1	30.6	69.4	1	0	15	85	1	1.1	98.9
Parwan	1	30.4	63.5	6.1	3	15.6	30.5	53.8	3	85.7	14.3	1	0.2	17.1	82.8	2	14.6	85.4
Wardak	3	44.8	53.4	1.9	3	50.2	20.6	29.2	3	99.1	0.9	1	0	8.4	91.6	3	39.6	60.4
Logar	2	37.3	60.5	2.2	3	68.5	8.2	23.2	3	97	3	1	0	13.6	86.4	3	47.8	52.2
Ghazni	3	42.3	54.0	3.7	2	8.5	10.7	80.8	2	60.3	39.7	1	0	16.1	83.9	2	20.4	79.6
Paktika	1	26.9	68.3	4.8	1	2	2.5	95.5	2	70.1	29.9	3	0	40.5	59.5	1	8	92
Paktya	2	40.4	57.0	2.6	2	20	13.9	66.1	2	64.4	35.6	2	0.6	21.4	78.1	2	14.3	85.7
Khost	3	45.8	52.1	2.1	2	25.1	14.8	60.1	2	63.6	36.4	3	0.5	37.1	62.4	2	16.8	83.2
Nangarhar	2	28.4	62.8	8.7	3	16.9	28.9	54.2	3	78.5	21.5	2	2.7	24.1	73.2	2	24.8	75.2
Kunar	1	22.3	64.2	13.5	1	7.2	6.2	86.6	2	73.5	26.5	3	0.2	49.1	50.7	2	18.8	81.2
Laghman	2	37.6	55.9	6.5	2	20.7	20.2	59.1	3	96.4	3.6	2	0	27.5	72.5	1	5	95
Nooristan	1	24.8	72.3	2.9	1	0	1.1	98.9	1	45.4	54.6	1	0	10.8	89.2	1	0.5	99.5
Badakhshan	3	45.0	51.5	3.5	1	2	6.1	91.8	3	77.5	22.5	2	0	20.1	79.9	2	15.2	84.8
Takhar	2	39.4	54.9	5.7	2	10.8	17.9	71.3	3	88.9	11.1	2	0.1	28.1	71.8	1	8.7	91.3
Baghlan	2	32.9	59.8	7.2	3	14.5	29.3	56.2	3	86.9	13.1	2	0.2	22	77.7	2	15.7	84.3
Kunduz	2	29.8	61.6	8.5	3	20.7	44.3	35.1	3	89.8	10.2	1	0	16	84	2	17.7	82.3
Samangan	2	35.9	58.0	6.1	2	7.1	15.1	77.8	3	94	6	1	0	12.3	87.7	1	2.9	97.1
Balkh	3	42.1	52.6	5.3	3	21.8	27.9	50.4	3	85.7	14.3	2	0.8	24	75.2	1	7.6	92.4
Jawzjan	2	33.8	57.9	8.3	3	20.9	23.5	55.6	2	63.2	36.8	3	0.4	41.4	58.2	1	3.8	96.2
Sar-I-Pul	1	22.2	69.0	8.8	2	4.8	12	83.2	2	62.6	37.4	1	0	9.6	90.4	1	2.3	97.7
Faryab	2	29.8	59.8	10.4	3	12	36.2	51.8	2	65.6	34.4	2	0	22	78	2	14.6	85.4
Badghis	1	25.9	68.9	5.2	1	0	0.8	99.2	2	63.2	36.8	1	0.2	17.6	82.2	1	6.5	93.5
Herat	2	35.0	57.5	7.4	2	19.7	20.9	59.3	2	59.1	40.9	2	4.5	25.4	70	2	21.9	78.1
Farah	2	37.3	60.2	2.5	2	12.9	11.3	75.9	1	41.5	58.5	2	0.9	21.9	77.1	2	27.9	72.1
Nimroz	3	45.5	52.8	1.7	2	19.1	5.8	75.2	2	57.5	42.5	2	0.3	28.4	71.2	3	36.8	63.2
Helmand	1	33.7	64.7	1.7	1	0.4	3.2	96.4	1	6.7	93.3	1	0.9	8.3	90.7	1	0	100
Kandahar	2	38.3	60.9	0.8	2	4.6	12.6	82.8	1	21.7	78.3	2	3	28	69	1	0.4	99.6
Zabul	1	32.2	64.6	3.1	1	3	4.2	92.9	1	35.8	64.2	2	0	33.9	66.1	1	0	100
Urozgan	1	18.4	79.4	2.2	1	0	0	100		0	0	1	0	18.7	81.3	1	0	100
Ghor	1	21.5	70.0	8.6	1	1.4	7.7	90.9	1	11.8	88.2	1	0	7.7	92.3	2	23	77
Bamyan	2	35.5	58.9	5.5	2	7.2	30	62.8	2	67.2	32.8	1	0	13.6	86.4	2	17.2	82.8
Panjsher	2	37.8	57.1	5.1	2	5.3	29.5	65.2	1	32.2	67.8	1	0.7	11.9	87.4	1	1.9	98.1
Daykundi	1	25.6	63.7	10.7	2	5	21.7	73.4	2	74.6	25.4	1	0	13.5	86.5	1	8.2	91.8

Definitions of not deprived, deprived and severely deprived for child development and environment	
Deprivation Level	No. of indicators failed
Severely deprived	3-4
Deprived (but not severely)	1-2
Not deprived	0

Definitions of not deprived (nd), deprived and severely deprived for reproductive health	
Deprivation Level	No. of indicators failed
Severely deprived	3-4
Deprived (but not severely)	1-2
Not deprived	0

Definitions of not deprived, deprived and severely deprived for child nutrition and child health	
Deprivation Level	No. of indicators failed
Deprived/Severely deprived	1
Not deprived	0

Source: Albert, Jose Ramon. Technical Report on Measuring and Monitoring Child Poverty in Afghanistan: An Examination Based on NRVA 2007/2008 and 2011/2012, March 2014

Annex 4 Child Poverty Indices: By Province based on NRVA 2011/2012

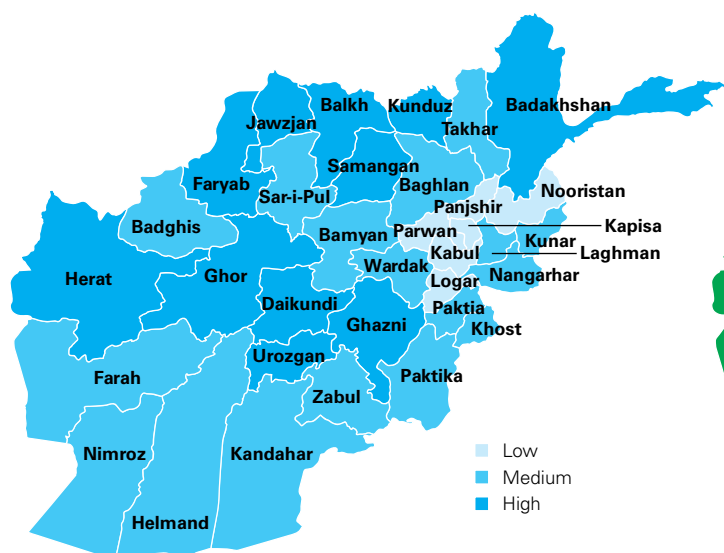
Province	Child Development				Reproductive Health				Child Nutrition			Environment			
	Cluster	Not deprived	Deprived		Cluster	Not deprived	Deprived		Cluster	Not deprived	Deprived	Cluster	Not deprived	Deprived	
			MD	SD			P	SP						MD	SD
Kabul	3	58.5	38.0	3.6	3	61.1	20.3	18.6	3	93.4	6.6	3	15.0	62.8	22.1
Kapisa	3	53.2	43.6	3.2	1	4.7	15.9	79.5	1	48.8	51.2	1	0.2	36.3	63.4
Parwan	2	41.8	51.3	6.8	2	14.0	22.4	63.6	3	91.0	9.0	1	3.5	42.6	53.8
Wardak	3	55.1	43.1	1.8	3	66.4	7.2	26.4	2	77.3	22.7	2	0.3	15.4	84.3
Logar	3	58.5	40.2	1.3	2	29.6	16.0	54.4	2	75.1	24.9	1	0.1	48.3	51.6
Ghazni	1	29.4	63.1	7.4	3	38.2	16.8	45.0	3	94.1	5.9	1	2.4	45.5	52.1
Paktika	2	41.9	53.1	5.1	3	35.9	41.7	22.5	2	77.6	22.4	1	0.3	43.0	56.6
Paktya	3	62.3	35.6	2.1	2	12.3	15.8	71.9	1	29.1	70.9	3	0.1	66.1	33.8
Khost	2	37.1	57.6	5.3	2	11.2	14.9	73.9	3	81.9	18.1	2	0.0	27.1	72.9
Nangarhar	1	27.7	66.4	5.9	1	6.8	13.1	80.1	3	92.9	7.1	2	0.1	19.2	80.7
Kunar	2	43.3	54.3	2.4	2	18.6	28.7	52.7	1	38.3	61.7	1	0.7	34.1	65.2
Laghman	2	40.0	56.7	3.2	1	3.1	14.3	82.5	2	74.2	25.8	3	0.6	59.5	39.9
Nooristan	1	29.2	65.8	5.0	3	35.0	28.3	36.7	3	87.6	12.4	3	0.5	63.3	36.2
Badakhshan	1	28.9	57.7	13.4	1	13.7	9.8	76.5	1	30.3	69.7	1	0.4	36.9	62.7
Takhar	1	23.6	65.7	10.7	1	7.8	15.2	76.9	2	58.7	41.3	1	0.8	31.8	67.5
Baghlan	1	25.1	71.2	3.6	1	0.2	1.1	98.7	1	3.1	96.9	2	0.0	18.5	81.5
Kunduz	2	35.3	59.8	4.9	2	8.1	23.8	68.1	1	46.4	53.6	1	0.1	33.4	66.5
Samangan	1	29.5	64.8	5.7	1	6.5	11.5	82.0	2	78.8	21.2	3	1.2	56.9	41.8
Balkh	1	25.5	68.5	6.0	1	5.6	10.9	83.6	1	28.1	71.9	2	0.1	27.0	72.9
Jawzjan	2	37.2	52.8	10.0	1	8.9	4.9	86.2	3	82.7	17.3	2	0.0	18.9	81.1
Sar-I-Pul	2	39.5	54.5	6.0	3	38.7	28.5	32.8	3	89.6	10.4	3	5.0	52.7	42.3
Faryab	1	24.1	61.8	14.1	2	9.5	21.2	69.3	2	63.7	36.3	2	0.0	23.7	76.3
Badghis	1	23.9	68.9	7.2	1	0.3	1.2	98.5	2	63.8	36.2	2	0.0	22.4	77.6
Herat	1	27.2	64.1	8.7	1	6.0	16.0	78.0	1	46.0	54.0	2	0.0	17.3	82.7
Farah	1	14.0	82.7	3.3	1	1.2	1.0	97.7	1	0.7	99.3	2	0.0	5.3	94.7
Nimroz	1	23.4	73.6	3.1	1	5.6	8.1	86.3	1	29.6	70.4	2	0.4	8.7	90.9
Helmand	1	26.3	70.3	3.4	2	15.4	27.1	57.6	1	25.2	74.8	1	3.6	42.3	54.2
Kandahar	1	24.4	64.3	11.3	2	17.9	17.9	64.2	1	36.4	63.6	2	0.5	19.8	79.7
Zabul	3	59.7	37.0	3.3	1	12.3	6.3	81.3	2	75.5	24.5	1	0.1	32.3	67.6
Urozgan	1	29.1	70.4	0.5	1	1.6	0.8	97.6	1	4.1	95.9	1	0.6	28.8	70.6
Ghor	1	25.3	70.8	4.8	1	1.3	8.4	90.3	1	19.6	80.4	3	0.6	59.2	40.3
Bamyan	2	31.7	60.7	7.6	2	18.2	21.0	60.8	2	69.0	31.0	3	9.8	47.9	42.4
Panjsher	2	41.3	55.1	3.6	2	22.5	15.4	62.1	2	74.6	25.4	3	1.5	77.2	21.3
Daykundi	2	41.5	53.7	4.8	3	34.9	14.1	51.1	2	73.1	26.9	2	0.7	26.2	73.1

Annex 5 Child Poverty Indices: List of Selected Indicators That Have Strong Correlation with Poverty

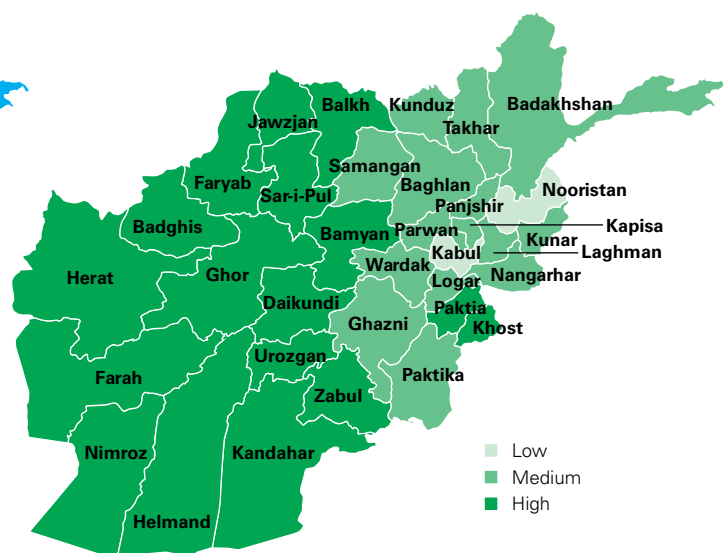
Dimension	Indicator
Child Development	Household with children aged 7-12 years not attending school
	Household with children aged 13 years who did not complete grade 6 or above
	Household with children aged 13-15 years not attending lower secondary or above school
	Household with children aged 0-17 years with no access to radio and TV
Reproductive Health	Births not attended by skilled health personnel
	Pregnant women who do not have at least one antenatal check during pregnancy by a health professional
Child Health	Children under 5 without DPT3 vaccines
Child Nutrition	Children under 5 who did not receive Vitamin A in the last 6 months
Household Environment	Children using unimproved toilet facilities or no toilet facilities
	Children using unimproved drinking water
	Children living in dwelling with no floor material (e.g. dirt/earth)
	Children living in rented dwelling

Annex 6 Natural Disaster Risk Maps

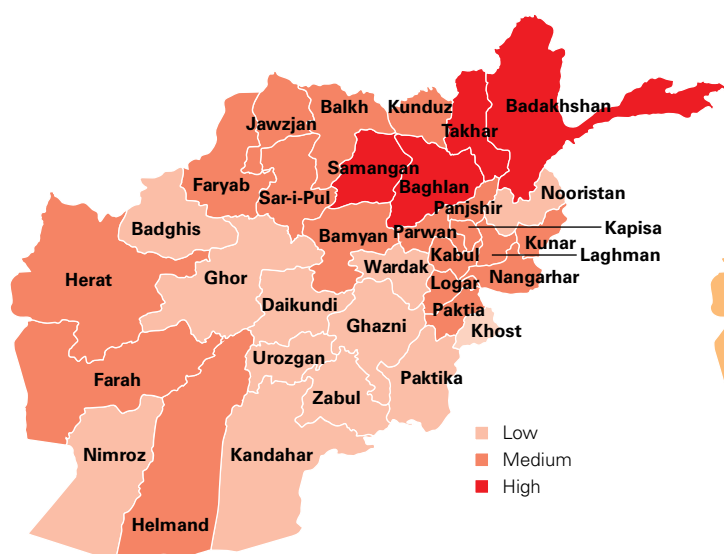
Flood



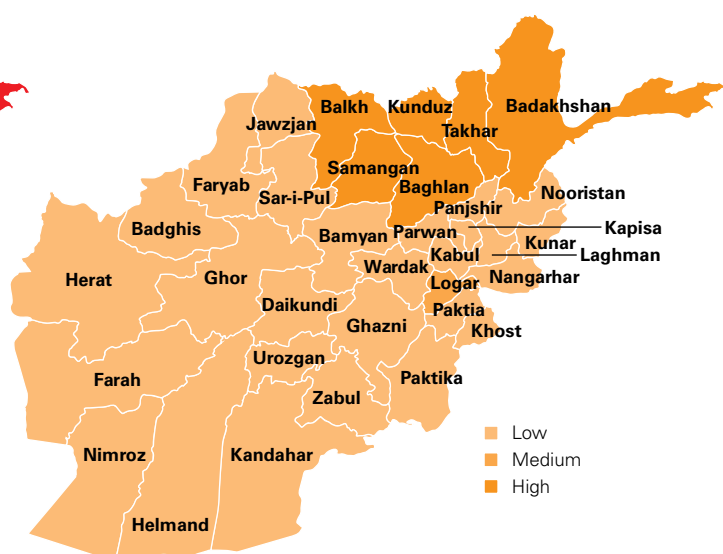
Drought



Earthquake



Landslide



Source: Afghanistan Natural Disaster Management Authority (ANDMA)

Annex 7 Health Facilities and Workforce by Province

Province	Population (2010/2011)	Health Facilities	Number of Nurses (F/M) (2011/2012)	Number of Female Midwives (2011/2012)	Number of General MD (F/M) (2011/2012)
Badakhshan	889,700	111	37/152	165	11/66
Badghis	464,100	45	4/58	42	3/17
Baghlan	848,500	63	19/92	108	9/33
Balkh	1,219,200	111	19/163	162	22/39
Bamyan	418,500	78	20/114	130	4/19
Daikundi	431,300	42	7/89	71	0/14
Farah	480,500	59	4/66	57	1/18
Faryab	931,800	72	23/67	93	24/26
Ghazni	1,149,400	86	36/124	122	2/60
Ghor	646,300	57	7/104	55	4/12
Helmand	864,600	62	5/144	66	0/41
Herat	1,744,700	100	30/150	148	18/57
Jawzjan	503,100	37	11/43	59	2/23
Kabul	3,818,700	192	46/112	216	60/123
Kandahar	1,127,000	60	19/127	76	2/45
Kapisa	413,000	43	3/69	75	1/35
Khost	537,800	37	15/44	42	0/39
Kunar	421,700	43	3/60	74	5/71
Kunduz	935,600	72	28/122	153	9/46
Laghman	417,200	43	5/63	76	7/72
Logar	367,000	47	0/71	81	2/51
Nangarhar	1,409,600	124	23/170	181	23/217
Nimroz	147,700	21	7/16	30	7/19
Nuristan	138,600	26	2/42	32	1/16
Paktika	407,100	34	1/54	23	0/16
Paktya	516,300	41	11/55	51	2/34
Panjsher	143,700	30	2/48	34	1/5
Parwan	620,900	80	0/130	108	3/71
Samangan	362,500	35	3/50	63	3/8
Sari-i-Pul	522,900	50	8/89	80	4/17
Takhar	917,700	76	26/125	148	10/35
Urozgan	328,000	75	0/42	14	0/17
Wardak	558,400	61	5/73	86	1/44
Zabul	284,600	23	4/49	18	0/8

Source: Calculated from HMIS, 2013

Annex 8 Student to Teacher Ratio (STR) by Province

Province	STR
Badghis	64.96
Nangarhar	54.69
Ghor	53.21
Nimroz	52.58
Daikundi	52.52
Nooristan	50.38
Urozgan	50.08
Ghazni	48.83
Laghman	48.78
Herat	48.76
Kunar	47.98
Samangan	47.14
Kunduz	46.29
Balkh	44.88
Helmand	44.85
Kandahar	44.32
Paktia	43.28
Jawzjan	42.47
Kabul City	42.05
Takhar	41.87
Sari-Pul	41.83
Faryab	41.7
Kapisa	41
Khost	40.34
Logar	40.19
Bamyan	39.32
Farah	38.52
Zabul	37.17
Baghlan	37.02
Kabul Province	35.93
Panjshir	35.01
Wardak	33.19
Paktika	32.5
Parwan	31.29
Badakhshan	31.05

Source: Calculated from EMIS 2011/2012

Annex 9 Percentage of Students who Enrol in Grade 1 Reaching Grade 5, by Sex and Province

Province	Female	Male	Total
Total	52.9	52.7	52.8
Badakhshan	74.3	62.4	67.8
Badghis	29.8	42.2	38.6
Baghlan	53.0	59.0	56.5
Balkh	59.2	53.6	56.0
Bamyan	67.0	50.1	57.1
Daikundi	81.2	74.7	77.6
Farah	46.5	57.4	54.0
Faryab	71.4	58.9	64.1
Ghazni	47.2	54.1	51.7
Ghor	79.9	83.0	81.7
Helmand	47.7	21.4	25.0
Herat	51.7	45.9	48.5
Jawzjan	64.7	68.4	66.9
Kabul	57.7	59.1	58.5
Kandahar	41.5	37.0	37.8
Kapisa	29.7	56.9	44.2
Khost	27.9	45.7	39.1
Kunar	50.4	53.7	52.3
Kunduz	51.6	53.4	52.7
Laghman	74.3	71.3	72.5
Logar	33.3	45.0	40.5
Nangarhar	38.9	48.3	44.3
Nimroz	39.2	42.9	41.2
Nooristan	65.7	70.5	68.4
Paktika	36.6	50.6	46.6
Paktya	25.2	43.8	37.2
Panjsher	31.6	48.8	40.6
Parwan	44.1	56.3	51.1
Samangan	66.9	63.4	64.7
Sari-Pul	58.1	53.5	55.4
Takhar	53.3	60.3	57.0
Urozgan	70.4	49.7	51.6
Wardak	45.0	52.4	49.8
Zabul	10.3	12.0	11.8

Source: Calculated from EMIS 2011/2012

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- ¹⁹⁶ They are likely to have less ability to access sanitary protection materials and may have challenges to wash, dry and dispose of materials as well as managing their menses with dignity.
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