



Health and education in Afghanistan: 10 Years After – Quantity Not Quality

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Agency Coordinating Body for Afghan Relief

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Abbreviations

Anp	Afghan national police	HMIS	Health Management Information System
AnSf	Afghan national Security forces	hp	health post
ACBAr	Afghanistan Coordinating Body for Afghan relief	idp	internally displaced persons
AndS	Afghanistan national Development Strategy	imf	international military forces
Aprp	Afghanistan peace and Reintegration Programme	imr	infant mortality rate
AOG	Armed Opposition Groups	ingo	international non-Governmental Organization
AdB	Asia Development Bank	LAS	Land Allocation Scheme
APEP	Afghanistan Primary Education Programme	ldm	local decision-maker
BeSSt	Building education Support Systems for Teachers	mmr	maternal mortality rate
BhC	Basic health Centres	MDG	Millennium Development Goal
BphS	Basic package of health Services	mohe	ministry of higher education
CDC	Community Development Council	moe	ministry of education
CHC	Comprehensive Health Centre	moISamd	ministry of labour, Social Affairs, martyrs and disabled
CHW	Community Health Worker	moph	ministry of public health
CSO	Civil Society organisation	ngo	Non-Governmental Organization
efA	education for All	NPP	National Priority Programme
eQuip	education Quality Improvement Programme	pACe-A	partnership for Advancing Community-Based Education in Afghanistan
EMIS	Education Management Information System	PED	Provincial Education Department
ephS	essential package of hospital Services	ttC	teacher training College
eu	european union	un	united nations
GoIRA	Government of Islamic republic of Afghanistan	uSAid	united States Agency for International Development
GER	Gross Enrollment Rate	WB	World Bank

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EXECUTIVE SUMMARY

Since 2001, significant effort has been made by the Government of the Islamic Republic of Afghanistan (GoIRA), supported by the international community, to improve healthcare and education. Access to basic health services has officially soared from approximately 9% to over 80% since 2001.¹ Whereas, only 900,000 children were enrolled in school in 2001, today the ministry of Education (MoE) puts the figure at approximately 7.3 million, with 37% of them being female students.² But all too often, the focus has been on increasing the quantity of services and their coverage, with too little attention given to the quality of these services, the ability of the population to use the services, or their sustainability. A decade after the 2001 intervention and 57 billion USD³ worth of external aid assistance later, millions of Afghans are still struggling to access basic health and education services. This lack of quality in the delivery of health and education services by both government and non-governmental actors is accompanied by growing

the Agency Coordinating Body for Afghan relief (ACBAR)⁴ undertook a study from July to September 2011 to look at health and education from the perspective of ordinary Afghans and non-governmental organisations (NGOs) working in the field. Focus group discussions and workshops addressed achievements, shortcomings and obstacles, coping strategies and change. According to the research findings, the main challenges in trying to provide health and education to Afghans are: a lack of awareness; insecurity; a lack of access to facilities; a lack of human resources capacity; and poor quality of services. Special attention needs to be given to the role of decision-makers and the needs of women and girls. Mental health, disability issues and migrant communities were particularly identified as areas where more work needs to be done.

needs and expectations of local communities within an increasingly insecure environment.



Awareness: the overall level of awareness within communities has increased in regard to the importance of utilising basic healthcare services and providing basic education. Females have low awareness about basic hygiene and health, resulting in complications with deliveries and lower general health levels in some areas. Significant gains have been made in the area of educational awareness, particularly on the importance of equal education for girls and boys.

Security: Sustained insecurity and violence has a major impact on the ability of essential services to be delivered to the Afghan population. Attacks on facilities, educational and health personnel and intimidation of students all affect the ability of the govt and NGOs to provide services. The extent to which insecurity affects service provision varies across the country. Raids and operations by the Afghan national Security forces (ANSF) and the international military forces (IMF), attacks and intimidation by armed opposition groups (AOGs) and tribal conflicts all negatively impact on the ability of the population to access services and service providers to deliver services. Criminal activity, such as kidnapping and robbery, affect the willingness of people to send their children to school and of professionals to travel within areas where they feel their safety is at risk. There is a paralysing fear and anxiety among the population that is not necessarily the result of recent attacks but a consequence of living in conflict for many years.

Lack of Access: The number of health and education facilities has grown significantly since 2001. This increase in quantity has meant that facilities are now present in many areas of the country that previously had little or no health or education infrastructure. The recognition of this achievement was consistent among 100% of the local respondents and NGOs who participated in the study.⁵ Lack of access to and availability of health and education services, however, continues to be a major issue which has damaged the perceived legitimacy of the government. People's access to those services is uneven and largely unmonitored. Questionable baseline data and a lack of research hinder the design of programmes to adequately address community needs. The youth population, which forms between 68 - 70% of the population,⁶ is concerned about the lack

of educational and vocational training opportunities, particularly in the provinces. Ultimately, poverty remains an important underlying factor in hindering access to healthcare and education, with a disproportionate effect on women and girls. The increased coverage claims of the government are not representative of the percentage of Afghans that actually have access to those services. **Lack of Human Resources:** there are not enough skilled workers in the health and education sectors. The "brain drain" that has plagued Afghanistan during the last few decades of conflict has resulted in a chronic lack of human capacity in the country today. The high levels of illiteracy and a lack of functional training facilities have further added to the problem.

The availability of human resources is low and this pool becomes even smaller when the requirement is for skilled workers. Many families require that only female teachers and health professionals attend to the girls and women in their family. Female professionals, however, are few in number. The push to roll out programmes and show results has meant that substantive practical human resources planning has been sacrificed.

Quality of Services: Significant investment has been made to develop the necessary physical infrastructure for providing healthcare and education services and training programmes that target health and education professionals. Unfortunately, projects often end there and fail to take measures to ensure that the services provided in the new buildings are of good quality or meet the needs of local communities. Professionals lack adequate training, vetting is poor, service providers are overloaded with tasks they are not capable of carrying out and remuneration is low. In addition to the lack of human capacity and poor physical infrastructure, there is a lack of equipment and disrupted funding flows. Finally, the limited capacity of GoIRA officials further complicates the ability of staff to provide quality services.

Women and Girls: Cultural barriers are still present throughout the country. However, awareness raising efforts have produced some positive changes. The lack of female professionals is further exacerbated by social and security-related barriers to education and movement.

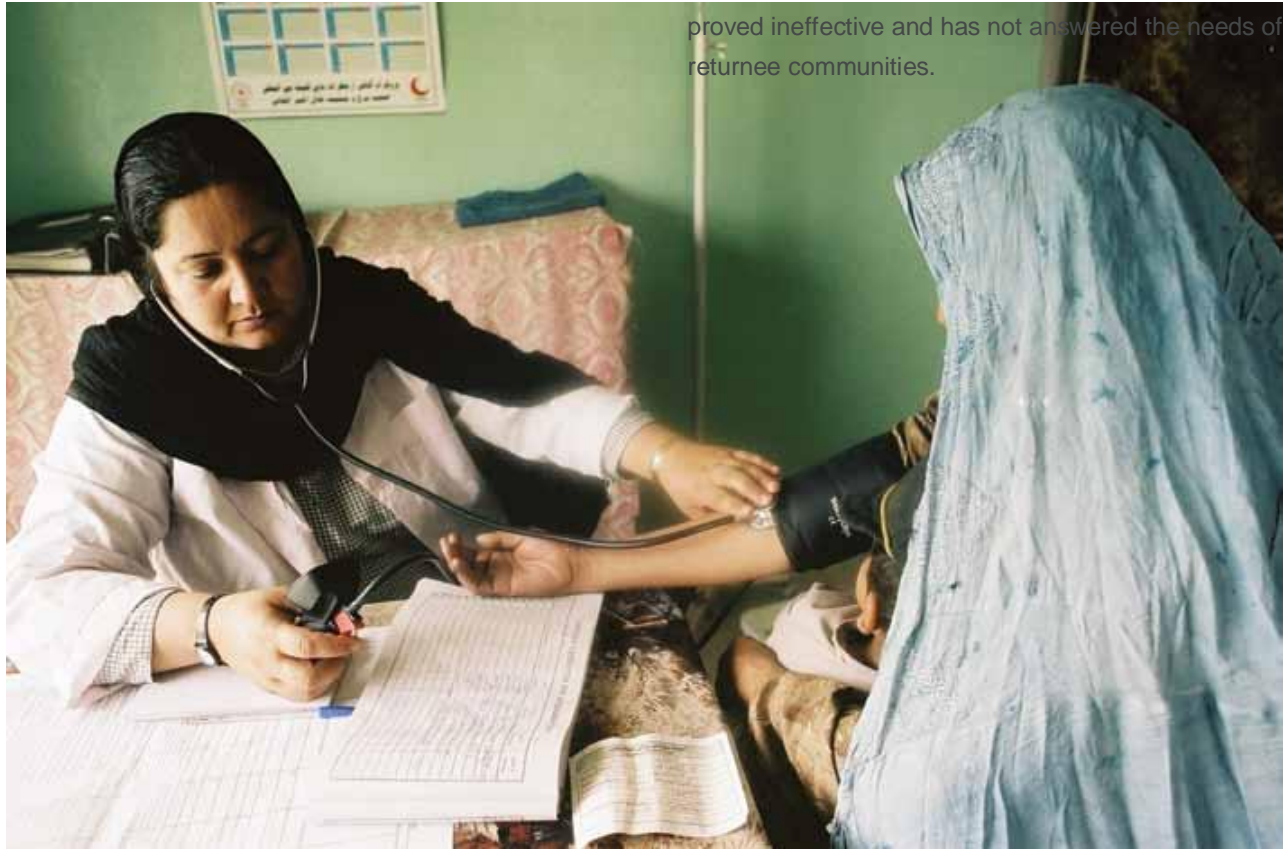
Women from rural and remote areas face discrimination at health facilities, with language barriers and low levels of education in some areas compounding the problem.

Barriers to movement, isolation and low levels of education have had a series of negative consequences for women and girls, from increased vulnerability to disempowerment. Women and girls are particularly vulnerable to security threats. Female professionals are targeted and harassed not just by AOGs and criminal gangs but also religious leaders and local decision-makers that oppose girls' education. Mental health problems, such as depression, are common among women facing persistent insecurity and there are no provisions or services available to help tackle this issue.

local decision-makers: religious leaders and shura⁷ members are key players in shaping community attitudes about health, education and gender issues. They are influential actors and can play a key role in facilitating access to services by identifying teachers and healthcare staff from the community and encouraging the community to provide security and accommodations for service providers. However, their power can also be used negatively when they discourage access to healthcare and education for women and girls, misuse community funds or manipulate programmes for personal benefit. The power that local decision makers hold on the access to and quality of basic services is indicative of the general absence of local government and the minimal influence that they have, particularly in the most remote and insecure areas.



Land Allocation Scheme (LAS) was initiated in 2005 and legalizes the distribution of uncultivated government land to landless returnees and idps. the LAS, however, has proved ineffective and has not answered the needs of returnee communities.



mental health: Psycho-social problems are not being addressed adequately at health or educational facilities.

There are few services provided for the large numbers of people that are psychologically traumatised by years of conflict and insecurity. Reports of mental health problems among marginalised groups such as women and youth are common. In addition, there is a close relationship between psycho-social problems and disability.

persons with disabilities: one of the consequences of years of conflict in Afghanistan is the large number of persons with disabilities. there is a lack of attention being given to the unique needs of this community in both the education and health sectors. the lack of transportation assistance acts as a disincentive to accessing services. there is a lack of skilled professionals trained to deal with the special needs of the disabled community. The quality of service received is low due to a lack of appropriate medicine, equipment and low levels of knowledge.

Though awareness has grown within communities about the rights of persons with disabilities, discrimination by community members is still a major obstacle.

migrants, displaced populations and returnees: migratory groups, such as kuchis, returnees and internally displaced persons (idps) are at a particular disadvantage in regard to the access and availability of services. the

migration in recent years. Many refugee returnees and IDPs have opted to simply squat on government and private land in urban centers. These informal settlements receive few, if any, government services and are mainly assisted by NGOs. Access to services can be hampered by local communities in the area who feel that the increased population hinders their access to already overloaded services.

With transition underway and the majority of international forces expected to withdraw by 2015, doubts are growing over the willingness of international donors to sustain their support to one of the world's poorest countries. This prospect leaves the positive gains of the last ten years looking increasingly fragile, undermines the impact and sustainability of previous donor and Afghan government investments, and threatens future efforts to tackle the lack of quality and capacity. Sustainability of services is reliant upon: sustained levels of donor funding; increased focus on improving the quality of services and substantive human resources capacity; the development of research programmes that shed clarity on the local reality; and the inclusion of, and better consultation with, Afghan civil society to help ensure development projects benefit from local knowledge.

faced with a lack of services and dwindling livelihood opportunities, there has been significant rural to urban



Key Overall Recommendations

International Community

- The international community needs to make long term funding commitments in both the health and education sectors with programming that focuses on increasing the quality, not just the quantity, of services and is disbursed with the primary objective of meeting local people's needs and alleviating poverty rather than serving political or security goals.
- Donors need to continue to prioritise female healthcare and education. The training of female professionals, health awareness raising and ensuring accessible emergency health services are key areas where interventions need to be focused.
- The international community needs to strengthen its monitoring and disbursement mechanisms to ensure quality programming is being delivered and aid assistance is being properly utilised.
- The international community must prioritise the needs of marginalised communities, such as persons with disabilities, or they will continue to experience increased vulnerability.
- Donors need to recognise the extent of mental health issues in Afghan communities and the role that it plays in hindering the ability of communities to absorb aid. increased support needs to be given for specialised treatment within health centres. There must be recognition of the impact of mental illness on the ability of students to learn within educational centres and the linkage between disability and mental health.
- International donors and the Government of Afghanistan must recognise urbanisation as a reintegration strategy for IDPs and returnees in development plans. Particular efforts must be directed towards ensuring there is requisite absorption capacity in terms of access to services and infrastructure for those residing in temporary or illegal informal settlements.

Government of Afghanistan

- Realistic human resource planning based on the actual capacity of the potential workforce needs to be undertaken. This will inform improved overall planning of service delivery, give focus to training programmes and allow the government to make more targeted

that are informed and designed according to assessments which evaluate the skills of workers and needs within the system. Follow-up evaluations need to focus on the extent to which training has improved capacity to deliver services.

- A review of the monitoring and evaluation systems used by the government needs to take place. Emphasis needs to be placed on the effective collection of information, the development of research initiatives that engage the community and the increased use of outcome and performance-based indicators.
- Training programmes need to target staff in rural areas. Continuous training and professional development opportunities need to be made available to people working at the sub-district level as part of the incentive package. focus needs to be put on overcoming key issues, such as barriers to movement for women in rural areas.
- Urgent attention needs to be given to the health and education needs of persons with disabilities. Programmes should focus on transportation support, social protection grants for health and education and upgrading facilities to make them accessible.
- LAS administration must be strengthened and better coordinated in order to ensure that settlers have access to needed services and that IAS is better supported with clinics and schools to avoid returnees migrating to the closest urban centre.

The NGO Community

- Sustainable programming needs to make use of resources within the community. Awareness programmes need to target religious leaders and local decision-makers. The Community Health Worker (CHW) programme has had varied results

interventions that do not overinflate community expectations.

- The National Priority Programmes (NPPs) should focus on the development of training programmes

but the training of older persons and youth within the community, particularly in peri-urban and rural areas, can have a more sustainable impact and increase the level of community ownership.

- Insecurity cannot be allowed to be used as an excuse for poor programming and monitoring.

Mechanisms need to be put in place that demand higher standards from agencies implementing programmes in insecure areas and by remote management to order improve the quality of services delivered.



APPROACH AND METHODOLOGY

In June 2011, ABCAR drafted a comprehensive advocacy strategy aimed at strengthening civil society voices ahead of

the Bonn Conference. the strategy incorporated a research component focused on health and education as these are two of the main areas where the international community and the government have claimed significant achievement and that are of great concern to the majority of local people. Cross-cutting issues of gender, local governance and security were also identified. The research findings have informed this report and the advocacy messages that will be raised by the ACBAR community in the lead up to the Bonn Conference in December 2011.

Consultations took place at the provincial level with local communities and individuals and at the regional level with NGOs and civil society organisations (CSOs). provincial focus group discussions were held in nine provinces. in total, 430 focus group participants from 14 provinces attended the consultations.

table 1: pfg Breakdown per research group type

	Female	Male	Youth	Local Decision-Makers	Persons with Disabilities	Kuchis
Total Number of Participants	114	127	62	57	58	12
Overall Percentage	27	30	14	13	13	3

Participants came from Mazar, Saripul, Samangan, Takhar, Herat, Ghor, Nangahar, Kunar, Laghman, Wardak, Kabul, Parwan, Kandahar and Bamiyan. Interviewees included groups of men, women, youths, people with disabilities, local decision-makers and Kuchis (nomads) between the ages of 15 and 90.

The focus group participants were identified through four

methods. Some participants were invited to participate in the study by ACBAR member organisations. These were both beneficiaries and non-beneficiaries of the particular agency's programming. Some participants were informed about the study through community shuras. Some heard about the study through other community members and asked to share their perspectives as well. lastly, the youth participants were all mobilised through AYNESO. Efforts were made to include health workers and teachers in the focus groups where possible.

Number of PFGs	13	13	7	7	7	1
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table2: Breakdown of provincial focus groups (pfgs)

	Total Number of Participants	Overall Percentage of Participants per Province	Total Number of PFGs
Mazar	53	12	6
Takhar	39	9	4
Bamiyan	41	10	6
Nangahar	83	19	8
Ghor	42	10	4
Herat	64	15	7
Kandahar	55	13	7
Kabul	53	12	6
TOTAL	430	100	48

regional level workshops were held with NGOs and CSOs in six regional centres across the country. in total, 66 organisations participated in the five regional workshops.

The majority of participants were from ACBAR member organisations. in kandahar and nangahar, however, agencies from outside of the ACBAR membership also attended the workshops.

Table 3: Regional NGO/CSO Workshop Participation

location	participants	organisations
mazar	16	14
Bamiyan	12	9
nangahar	16	14
herat	22	17
kandahar	15	11
total	81	65

The focus group methodology design ensured the inclusion of marginalised groups. Efforts were made to achieve an urban – rural balance. Participants from the outlying districts were encouraged to come to the focus groups and share their perspectives. the gender balance between male and female focus groups was approximately 50/50. Separate focus groups were held with youth, persons with disabilities and Kuchis to give the research team a deeper understanding of health and education realities from diverse perspectives. the local decision-makers (ldm) group included tribal elders, Community Development Council (CDC) members as well as religious leaders. The study was limited, however, in its ability to access large numbers of participants from remote areas. In addition, it was difficult to achieve a 50/50 gender balance in terms of the overall number of participants. Efforts were made to include

women and young girls in the youth, LDM and Persons with Disabilities focus groups; however, the majority of these focus groups contained more male participants than female.¹⁰ The Kuchis focus group consisted of only males.

A three-pronged approach was adopted to facilitate triangulation¹¹ of the research findings. The insights provided during the consultations were enhanced by a desk review of relevant reports and policy documents and a series of individual interviews with technical experts. This approach strengthened the research study by allowing the consideration of a variety of perspectives and experiences. It also allowed the researchers to identify gaps, common themes and disparities between the government, community and international discourses. A qualitative rather than quantitative methodology was chosen in order to give people the opportunity to express their concerns and share their experiences fully rather than having to rely on statistical analysis. As a result, a comprehensive picture of the health and education sectors and their challenges and successes was formed. The following report outlines what ACBAR sees as the main challenges of the current situation and provides suggestions for a way forward. The analysis and policy recommendations are drawn from the 430 local voices and the input of 66 organisations that participated in the research study.



BACKGROUND

Developing nations have many challenges related to the development and growth of their public services. Afghanistan is one of the poorest countries in the world and it is therefore not surprising that the state of health and education services in the country is poor. The situation is further complicated by many factors that plague post-conflict countries, including: an unstable political system; poor economy; and ongoing violence. Consequently, the public service delivery system in Afghanistan has been severely affected. Ten years after the fall of the Taliban, the Afghan government still finds itself struggling to provide basic services to the population.

In 2001, when the Taliban fell, Afghanistan was faced with some of the lowest health and education indicators in the world. The maternal mortality rate (MMR) was 1,800 deaths per 100,000 live births.¹² In some rural areas, however, the MMR was as high as 6,507 per 100,000 births.¹³ The infant mortality rate (IMR) was 165 in every 1,000 births and life expectancy was 44.5 years.¹⁴ Official figures put the gross enrollment rate (GER) at 38% for boys' primary education and 3% for girls'. An estimated 80% of school buildings at all levels

Already weak education and health systems that had had been damaged or destroyed.¹⁵ The curriculum had not been revised for 30 years, and virtually no modern pedagogy practices had been introduced for decades. Afghanistan had one of the most unhealthy, illiterate and uneducated populations in the world.

struggled to meet the demands of the population were almost completely decimated as a consequence of years of war.

Since 2002, both the health and education sectors have expanded rapidly. A series of strategic plans and international compacts have guided the planning, expansion and delivery of health and education services. the moph was able to rapidly expand the provision of primary healthcare under the Basic Package of Health Services (BphS) and essential package of hospital Services (ephS)¹⁶ using a flexible contracting out procedure which incorporated ngos who had already been the main health services providers for decades

and had access to insecure areas where the government did not. In addition, since 2005 a growing number of newly established national NGOs have become the main contractors for the BPHS. The BPHS includes a set of high-impact interventions aimed at addressing the principal health problems of the population, with an emphasis on the health of women and children. The EPHS identifies a standardized package of hospital services for each level of hospital. it provides guidance on how the hospital sector should be staffed, equipped, and provided with materials and pharmaceuticals and includes a referral component which tries to create linkages between hospitals and the BphS facilities.

Table 4: External Assistance for Reconstruction and Development ONLY (2002-2010)¹⁷

Category	Billions in uSd
Total Committed	37.6
total disbursed	28.1
Total Committed - Health	2.22
total disbursed - health	1.75
Total Committed - Education	2.41
total disbursed - education	1.72

The implementation of programmes such as the Education Quality Improvement Programme (EQUIP), supported by the World Bank (WB), the partnership for Advancing Community-based Education in Afghanistan (PACE-A), and the Afghanistan Primary Education Programme (APEP), the Building Education Support Systems for teachers (BeSSt) (funded by the United States Agency for International Development (USAID) in coordination with numerous school construction projects) facilitated the increase in schools buildings, students and teachers across the country. Large scale textbook production and distribution programmes have been implemented to support the growing student population across the country. In addition, overall aid for basic education has increased more than fivefold in Afghanistan over the past five years.¹⁸

The GoIRA and the international community continue to invest in the health and education sectors. In 2004,

SITUATION ANALYSIS

Health

One of the major changes over the past ten years cited by NGOs was the increased level of knowledge within communities about basic healthcare. This increase was accredited to effective community education programmes and outreach efforts. More women are using formal healthcare services for ante and post natal care and deliveries. Awareness about the importance of having children vaccinated has grown.

Even though achievements have been made in increased awareness, the overall level of knowledge in communities, especially in rural and remote areas, is still low and acts as

an Afghan version of the Millennium Development goals (MDGs)¹⁹ was endorsed. At the Kabul Conference, held in Kabul in 2010, high level Afghan government officials and foreign experts endorsed an action plan to improve social and economic development, governance and security guided by the Afghanistan National Development Strategy (ANDS). At that time, 22 National Priority Programmes (NPPs)²⁰, organised into five clusters, were developed and committed to by external donors. Many of the NPPs touch on issues that will impact health and education. The NPP Human Resources Development Cluster contains three programmes that deal specifically with the Health and Education Sectors: education for All; higher education; and Human Resources for Health. At the time this report was written, the mentioned documents are waiting to be endorsed, unfortunately having undergone very little consultation with civil society.

An obstacle to the development of healthy communities. People are often unaware of how to attend to minor health issues which, when left unattended, sometimes lead to more chronic problems. Female focus group participants spoke of a lack of awareness among women in rural areas regarding basic hygiene and nutrition during pregnancy. Only one-third of women have at least one antenatal visit during pregnancy. Nearly 75% of women deliver without the assistance of health personnel and in rural areas this number increases to 93%.²¹ Healthcare workers interviewed stated the fact that women often work in the fields until they are ready to deliver, wait too long after labour has started to seek medical assistance and do not visit the doctor afterwards to check on their health contributed to the high maternal mortality rates. The lack of awareness among women about basic hygiene and reproductive health remains a significant challenge to maintaining healthy mothers

and children. This is a particular concern in emergency situations, such as floods, earthquakes and displacement due to conflict, where the lack of awareness and knowledge is compounded by the effects of shock.



Testimony, Ghor

Many communities still do not understand the way the healthcare system operates under the BPHS and are unaware of what services should be provided at various facilities. The lack of knowledge about healthcare services among communities and particularly marginalised groups hampers their ability to access services and maintain a healthy lifestyle. Women are at a particular disadvantage because of isolation and cultural barriers. People are often unaware of where to go for treatment and unable to assert their rights due to lack of knowledge about the system and where to address complaints and malpractice cases. A weak referral system, regular turnover of NGO service providers and the diminished capacity of healthcare workers further

education. evidence of this is seen in increased enrollment rates of girls since 2001. According to the MoE, today, 38% (or 2.7 million) of total students are girls.²² The value that is placed on education within communities has grown. this is a result of increased availability of education facilities, outreach programmes and migration. Though the country is still embroiled in conflict, a space has been created that allows communities, at least in more secure areas, to acknowledge the longer term benefits of educational investment and literacy.

Testimony, Takhar

The increased presence of schools in many areas of the country, coupled with NGO and government awareness programmes about the importance of basic education and literacy, has encouraged communities to invest in education for their children. The experiences of returnee communities coming back from Pakistan and Iran, where education was available for both boys and girls, has contributed to a gradual change towards education within communities.

Education

Significant positive gains have been made in the area of community awareness, especially regarding women's



Testimony, Kandahar

insecurity is a challenge to the delivery of quality health and education services in Afghanistan. It is a complex problem that affects different actors in different ways. the type of insecurity in the area, the groups involved and the associated service delivery problems and coping strategies vary greatly from province to province

and sometimes from district to district. Focus group participants in regions where security was not listed as a major concern, such as Bamiyan, spoke of being marginalised as aid flows were focused on insecure areas. Communities are facing security threats from a variety of sources including the imf and Aogs and more localised insecurity due to local commanders and tribal clashes. In some areas where AOGs are actively operating they are not blocking and sometimes even facilitate people's access to public services but, because of the low quality of services, people are still unable to receive assistance. This can negatively affect people's confidence in the legitimacy of the government, its ability to deliver services and also its ability to control levels of insecurity. Criminality is a growing issue in the urban centres, along well travelled routes and also against valuable targets such as teachers and doctors.

In areas struggling with insecurity, monitoring and evaluation of service delivery and of the community's ability to access these services may be sporadic, done by remote management, or neglected completely. Local people from the area may be able to travel to a school or health facilities but supervisory staff coming from outside the area to conduct monitoring and quality assurance checks may be targeted or face difficulties. In such cases, even though security does not act as an obstacle to the population – people can access services – the quality of services may still be poor because of the lack of monitoring and supervision in the area as a result of insecurity.

People's perceptions and beliefs about the level of insecurity in an area, whether rooted in fact or not, may act as a more debilitating factor than actual incidents of violence. there is a paralysing fear within the population that is not necessarily the result of recent attacks or insecurity but a consequence of living in conflict for many years. In addition, the negative psycho-social effects of the conflict are being seen more within communities. Focus group participants in all 9 provinces spoke of increased feelings of anxiety and fear, the poor performance of students and the presence of mental health problems due to sustained exposure to trauma, violence and instability. there is a strong linkage between the psychological impact of insecurity and the ability of communities to absorb health and education aid.

NGO Testimony, Bamiyan

Testimony, Samangan

there was little knowledge or understanding of the transition process, the peace process and related programmes such as the Afghanistan Peace and Reintegration Programme (APRP) within the communities interviewed. NGOs were more informed and expressed concern regarding the effect the transition of the military forces would have on security and funding for programmes. People are unsure how these processes

will affect their lives and are occupied with more immediate localised concerns. There were differences in the levels of knowledge various groups had concerning transition and the peace process. The youth and local decision-makers seemed to be more informed than other groups such as women. Focus groups in Jalalabad and Kandahar, where there are ongoing military operations, had a heightened awareness of the pending withdrawal of international troops than other areas like Ghor where security problems are more localised. These initiatives are seen as being something that happens far away and decided by political actors, interests and the international community.



because staff are often too scared to come back to work and the communities are too scared to come to the clinic. reasons for the raids are often not provided. the raids are inconsistent with the Additional protocols geneva Conventions of 1949 and 1977 (Article 12)²⁶.



in July 2011, the un Security Council adopted resolution 1998 (2011)²³ which recognized attacks on schools and hospitals as a grave violation of children's rights. The 2011 Annual Report listed a total of 197 education-related including direct attacks against schools, collateral damage, killing and injury of students and teachers, threats and intimidations and forced school closures. The report also verified 47 incidents affecting health service delivery in 2010 which included the abduction of medical staff, the looting of medical supplies, improvised explosive device attacks, collateral damage and intimidation²⁴. Resolution 1998 took an additional step by calling for perpetrators of such violence to be listed in the Secretary General's Annual Report on Children and Armed Conflict. The 2011 report already names both the Afghan national police (Anp) and the taliban²⁵ as parties that abuse the rights of children in situations of armed conflict.

Health

Raids and operations by the IMF, attacks and intimidation by AOGs and power struggles between local commanders and tribal conflicts all negatively impact on the ability of the population to access services and the ability of service providers to deliver services. people in the Southern and the eastern regions relayed incidents of being prevented from going to clinics by IMF roadblocks, sometimes even in emergency cases, for hours at a time. NGOs discussed the double negative impact of IMF raids on clinics. They said raids affect provision and accessibility of services

There is no policy or strategy framework put in place to address the significant health service shortcomings caused by insecurity²⁷ throughout the country.

People commented that access to clinics is usually not

directly prevented by Taliban or other armed groups. Attacks and intimidation by AOGs preventing access to healthcare facilities were not frequently cited. According to NGOs, if an attack occurs it is more likely to be directly against a staff member or focused on acquiring medicine and equipment or physical assets, like ambulances, than aimed at destroying the health facility itself. As a result of these actions, healthcare facilities that should be able to provide services to the community are unable to do so because of a lack of human, financial or physical resources. The prevalence of criminality is becoming a growing concern. NGOs in all regions included in the study referenced the increased difficulty in recruiting staff in areas plagued by criminal activity. In such cases, some communities have mobilised to ensure the safety of health professionals travelling to work in the villages. In areas where there are several types of insecurity, however, communities said that they were unable to guarantee the safety of professionals coming from outside the area. This has a two pronged affect. It makes it harder to bring professionals from outside the area to train others and it also makes it harder to take willing individuals out of the area in order to be trained elsewhere. Harassment of healthcare workers was also cited as a reason why professionals leave their employment and take on jobs that are sometimes outside of their field but make them less vulnerable.



among healthcare staff. This was mainly due to the fact that many healthcare staff receive additional salary from private sector institutions, which can substantially increase their income and make them a prime target for criminal groups. This is rarely the case for teachers.



Education

Parents expressed concern for their children's safety because of both ongoing and regular military operations and tribal conflicts. However, raids on schools or roadblocks by IMF which hamper access to schools were described as limited. Parents were more worried that children would be injured or killed from the collateral damage of military operations or tribal conflicts. Attacks on educational facilities by Aog groups were cited as being more frequent than attacks on health facilities. NGOs commented that attacks were more common on government schools. Yet, it was also noted that people were not always clear on who was running the school and, in such areas, ngo schools were as vulnerable as government schools. This was confirmed by the insights given in the focus group discussions. Participants commented that, in areas where there are many and changing actors and areas where community members are not consulted, there can be confusion within the community as to who is doing what. One of the major issues mentioned by participants was the targeting and harassment of teachers not just by AOGs but also by criminal elements in the community. Many night letter distributions within the community were cited, particularly those targeted at female teachers or families sending their girls to school. Robbery was less of an issue with staff of education facilities than

The kidnapping and harassment of students, particularly girls, was raised as an issue in herat, nangahar and kandahar. respondents spoke of not sending their children to school, not only due to on-going or recent attacks but out of a fear that had developed after previous attacks or threats and the trauma of living through years of conflict and violence. Once an incident occurs within the community it will interrupt the education of the students. According to people's perceptions, this happens in two ways. parents tend to keep their children at home, sometimes even for months, after an attack or criminal incident occurs. In addition, students will become fearful and even depressed, affecting their ability to absorb information and learn.

The MoE has been actively working to reduce the number of attacks against schools, such as the development of a directorate of Security and protection. in addition, an integral part of the 'improved institutional development goal' of the Education forAll NPP is improved security and protection. The programme incorporates activities such as the development of security systems for education offices and educational institutes with awareness training and guidelines for key staff and students on possible threats.

Testimony, Kandahar



is a major problem for large segments of the population. this lack of access is attributed to a physical absence of clinics and necessary infrastructure, short hours of operation of health centres, lack of availability of health workers and a lack of knowledge about health services.

Health

The overall increase in the number of people that have access to healthcare has been one of the major achievements of last decade. In 2002, it was estimated that approximately only 9% of the population had access to healthcare services. Nine years later, according to official figures by the MoPH, the BPHS is available to 85% of the population.²⁸ This is reported by the MoPH and GoIRA to have improved the quality of life for millions of Afghans.

The MoPH access figures, however, only represent the contractual district coverage of the BphS, or rather the percentage of the population that live in districts in which primary care services are provided by NGOs under

contracts with the moph or through grants to the ngos.

The official figures do not represent the actual access to services of the population in rural or remote areas of those districts. This is misleading and communicates

a false sense of achievement in terms of access to

healthcare available to Afghans across the country. the new goal set out in the moph Strategic plan for 2011-2015 is for 65% of the population to have access to a

health facility within two hours walking distance by 2013.²⁹ Currently, 60% of the rural population lives more than an hour's travel time from any health facility³⁰ and 85% live within one hour's distance by any means of transportation, including by car³¹.

This last statistic includes villagers in remote areas who would have to walk 5 or 6 hours to a clinic but are only one hour away if they had access to a car. lack of transportation and physical infrastructure, such as roads, present major challenges to healthcare access both for service providers trying to access the population and also for patients trying to receive medical assistance. This is particularly the case in rural, mountainous and remote areas. NGOs confirmed that coverage is significantly less than represented by

official figures and that lack of access to health services

NGO testimony, Eastern Region

Reports of non-operational clinics were common throughout the study. Some NGOs reported that they were unable to provide the services agreed upon due to lack of funding and geographical obstacles. Clinics were either not able to be opened or had to be closed. As a result of these closures, in some areas the residents had to travel to the district or provincial hospital for medical care.

In some places where clinics are present they are only open and offering services to the public on a limited basis. People interviewed reported that many clinics, even those at the district level, have limited hours of operation and usually close by midday. People living in rural or remote areas cannot afford to visit the clinic numerous

times in an attempt to see a doctor or nurse. In some areas, clinics are closed for several days during the week due to corruption and insecurity. people reported occasions where health directors were paid to close the clinic early. doctors often use the public facilities as a place to find patients for their private practices. They work reduced hours at the public facilities and then refer and treat the majority of patients at their private practice. patients are charged exorbitant rates for the consultation and medicine at private health facilities. This places a financial burden upon patients who are often already suffering from poverty. The situation becomes even more dire when one considers the mobility and financial obstacles that persons with disabilities or mental problems may face. If an emergency situation occurs in the evening, or at night, patients often have to travel to the provincial hospital to get assistance. in the rural and remote areas this is usually impossible, especially for women travelling at night due to emergency situations in areas where this is culturally difficult.

Testimony, Herat



Coverage is ensured by the six types of facilities offered under the BPHS. The most basic level of the BphS is the health post (hp), which is staffed by one male and one female CHW, who are voluntary non-professional staff. there are over 10,000 health posts across the country. ChWs are supposed to cover areas of 1,000 – 1,500 people³².

In remote areas, where villages are far away from each other, it is difficult to maintain this coverage. CHWs tend to be poorly trained, unable to deliver all of the services they are supposed to and are unaware of how to utilise the referral system. When available, CHWs are often unable to offer proper assistance and cannot refer patients to the next appropriate level of the BphS due to lack of knowledge and/or mobility. This means that the first level of the BPHS is not operating in all of the targeted areas. in addition, the BphS is dependant on the idea that all services in the package should be available as an integrated whole as opposed to individual services. Lack of knowledge about the referral system –

Education

The number of schools in Afghanistan has risen from 3,400 in 2001 to over 13,000 in 2011.³³ this increase in infrastructure has meant that, today, education is available to more Afghan children than ever before in history. The increase in students enrolled in both Islamic and secular schools has seen a similar jump going from 900,000 in 2002 to 7.3 million in 2011.³⁴

Testimony, Laghman

However, lack of access to schools was one of the major frustrations that came out of the research study. 50% of the school-aged population still do not have access to basic education due to a lack of physical infrastructure.³⁵ In addition, of the 7.3 million students enrolled in schools approximately 15%, or nearly one million, are said to be “permanently absent.”³⁶ In some districts, people reported that students travel up to three hours per day in each direction to reach primary schools. In other areas, where the remoteness of the area or security issues prevents students from travel ing alone for so many hours, children go without an education.

a system designed to link the different facilities together – is widespread among CHWs and qualified healthcare staff at the other levels of the BphS.

the discrepancies can also be found in the different levels of schooling. grades 1 to 6 are considered primary schooling. Grades 7 to 9 are classified as lower secondary. Together, the first nine years of schooling comprises a complete cycle of basic education.³⁷ Little investment has been made into the lower secondary schools. there is a lack of teachers and an outdated curriculum. As a result, many of the lower secondary

schools cannot teach the students through to Grade 9 and, when classes are offered, the quality of teaching is very low. In addition, hardly any investment has been made into upper secondary school teaching Grades 10 to 12, which is part of the reason why there is a shortage of qualified health and education professionals.

Testimony, Takhar



Almost 45% of school buildings, however, are without

usable buildings, boundary walls, safe drinking water or sanitation facilities³⁸ and the students that do attend are at risk of developing serious illnesses and health problems.

A commonly cited reason for not sending girls to school was the absence of the boundary wall. 68% of schools do not have boundary walls and 15% require rehabilitation of their boundary walls.³⁹ Schools without boundary walls³⁹ leave students vulnerable to outsiders during break-times. Other impediments to access include poor planning and placement of schools, unusable school buildings and high levels of teacher absenteeism.

NGOs commented that uneven distribution of schools has resulted in some areas being overserved while others go without schools. MoE is structured around a central Ministry in Kabul and provincial and district departments in all 34 provinces. The Provincial Education Departments (PED) are responsible for providing the MoE with suggestions for the placement of schools. The mapping of schools is decentralised by the MoE. Both focus groups participants and NGOs commented that the subjectivity of this exercise paves the way for favouritism and patronage. A lack of oversight means that rural or remote areas are sometimes left out of the plan even if they do not have schools in the area. Organised community efforts that aimed to address this uneven distribution were reported to be unsuccessful for the most part. Local decision-makers commented that government officials often do not take their requests for schools seriously.

Testimony, Nangahar

There has been a major increase in the number of Grade 12 graduates since 2001 given the significantly increased number of students attending school.

However, the higher education institutes are unable to absorb this increased number of graduates. 20% of students that pass the Kankor exam are unable to secure a place within a higher education institute.

The Higher Education NPP aims to increase access by expanding facilities and raise the number of students from 62,000 (2008) to 115,000 by 2014.⁴⁰

Given the gap that already exists it will be very difficult

The MoE has created the Education Management Information System (EMIS) which has facilitated the collection of data in the majority of the country. Much more is known now than before about the education situation. However, the manner in which the data is collected and analysed, the absence of census data, corruption within the system and inability to access some areas due to insecurity and remoteness result in inflated or inaccurate figures. This makes it difficult to calculate things such as the number of students, the number of school-age children and the gender parity within schools. The goRA has committed itself to achieving six Education for All (EFA) goals and a modified version of the global MDGs. The Afghan MDGs have set a target of 100% participation in primary education by 2020. Unreliable data hinders the possibility to accurately assess Afghanistan's progress towards achieving these goals.

Health

The lack of skilled workers is a major issue for NGOs attempting to deliver health services to the population. Local respondents spoke of the availability of only a few healthcare workers, and almost no female healthcare workers, and expressed low confidence in the medical skills of the health workers that were available. For positions that require less training or sophisticated levels of knowledge, such as CHWs, recruitment of staff has been easier for NGOs, though a gap still persists in the recruitment of female CHWs. There are approximately 18,000 CHW countrywide, with 37% being female.⁴¹

The gap is more evident when trying to locate skilled doctors, nurses and medical specialists, such as physiotherapists and gynaecologists. Some components of the BPHS are not implementable at all because of this lack of human resources. The mental health component of the BPHS requires one psychosocial counselor to be present in every Comprehensive Health Centre (CHC). There are not enough people trained in psychosocial counseling within the entire country to fill that requirement. This has a significant impact on the ability of NGOs to provide this service.

to achieve this goal and facilitate access for such a large number of students.

One of the major impediments to assessing improvements in the education system in Afghanistan is the difficulty of collecting and analysing data.

Testimony, Laghman



in schools. in addition, according to the moe, based on current demographic trends, even with drop-outs, by 2020 Afghanistan will require an additional 99,000 teachers at the primary school level and an additional 112,000 teachers at the secondary school level at a cost of approximately 495 million USD.⁴³



Rural and remote areas are particularly affected by the lack of skilled workers. illiteracy tends to be higher and skilled professionals are resistant to work in areas where they are unfamiliar. The majority of skilled medical professionals are based in the urban areas. NGOs stressed that they face difficulty recruiting staff to work in insecure and remote areas and in retaining staff due to low salaries and standards of living offered in the outlying areas. Professionals working in rural areas face a lack of services available for their families, cultural barriers like language and limited professional growth opportunities for promotion and training. A number of healthcare staff commute from the city to the rural areas daily but this affects their availability and increases their vulnerability to insecurity and criminality. They are prevented from reaching communities because of distance, lack of transportation and the cost of daily travel. As a result, health facilities in the rural and remote areas are often not fully staffed or have to operate with staff that are not properly trained.

Education

There have been major efforts on the part of the MoE and the donor community to increase the number of teachers within Afghanistan to accommodate the need among students and growth in the quantity of schools. Between 2001 and 2010 there was an eight-fold increase in the number of teachers, over 170,000 of which (30%) are female.⁴² Whilst the number of teachers has dramatically increased, there are still not enough teachers to educate the number of students enrolled

every province in the country now has at least one TTC.⁴⁴ there are currently 42 TTCs across the country but only 17 are housed in usable buildings, only 18 have dormitories for female, and only 36 have dormitories for males.⁴⁵ in provinces outside of Kabul, particularly for educated women, the TTCs are the only option for further education, training and employment. Teaching, however, is not seen as an attractive option for those who have access to higher education. the low salary, heavy workload and poor conditions of schools act as a deterrent. This means that the recruitment pool, even for female teachers, keeps growing, but the retention rate is low. graduates are unlikely to remain teachers if other opportunities are made available. Therefore, the number of students graduating from the TTC may not be a true reflection of the number of teachers entering the educational sector for employment. This is particularly the case with female teachers. In addition, it is difficult to find teachers, especially among females in the rural areas, who meet the Grade 12 requisite for the TTC.⁴⁶ As a result, the TTC model itself may not be effectively able to recruit the number of teachers needed for the education system in Afghanistan. Whilst significant donor funding has been inputted into this model not enough has been done to improve and accredit those who are already teaching but have not met the minimum education standard.

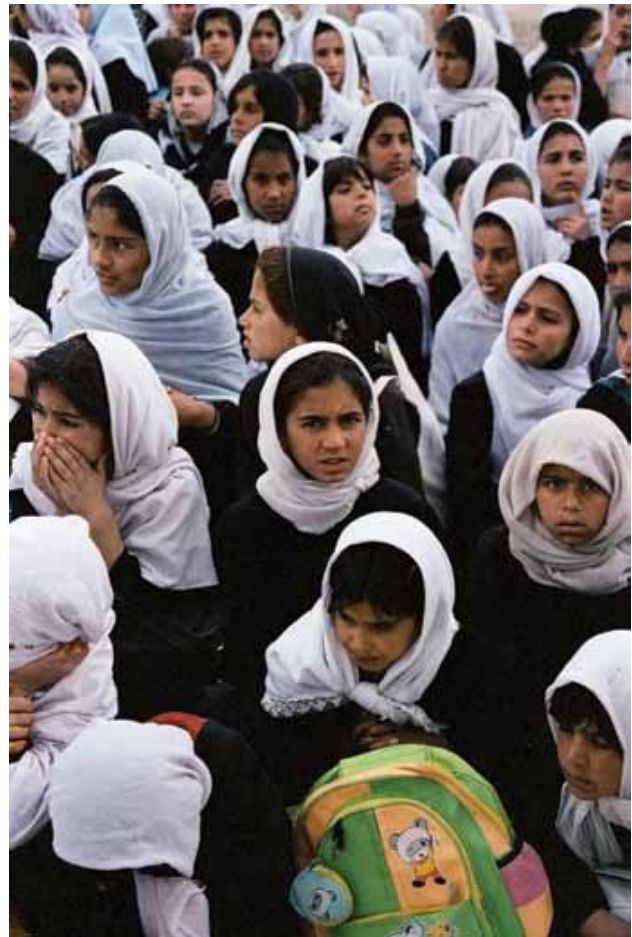
NGO Testimony, Herat

Health

There have been many successes in the healthcare field in Afghanistan over the past ten years. The number of medical schools and training institutes has increased. There are now six medical schools in Afghanistan with approximately 8,000 students. There are nine institutes of health sciences that prepare nurses, midwives, and other health professionals with an enrollment of approximately 3,500 students.⁴⁷ Vaccinations programmes targeting polio and tuberculosis have been hugely successful in both coverage and awareness rising within communities. Many health indicators have improved significantly. low quality of healthcare service provision, however, is a widespread problem. Professionals are receiving poor quality training. there is an absence of vetting processes, continuous quality improvement programmes for staff and a regularised and functioning monitoring and supervision system. The low salary fails to attract the most competent individuals, acts as a disincentive for providing quality service and is an impetus for corruption. this lack of knowledge and capacity of staff is further compounded by regularly cited cases of inadequate resources, including a lack of equipment, medicine and ambulances.

Testimony, Herat

The low level of knowledge among medical professionals due to poor training and the failure to attract the most competent is a major problem that results in frequent misdiagnoses of illnesses, malpractice and even death. A lack of training laboratories and updated materials means that even professionals who have graduated from higher learning institutes may not be prepared to respond to the public's needs and are sometimes unable to perform even basic procedures at the health facilities. This reaffirms an already present preference for private sector healthcare among the population, which forces poor families into debt and excludes the poorest families



training is provided for healthcare staff but there is little evidence that this has led to improvements in the from receiving quality healthcare.

Testimony, Saripul

provision of health services. training is not designed based on staff needs assessments. Instead, programmes tend to be donor driven and focused on the quantity of people trained and not the quality of the training or the skills transfer. the quality of trainers is low. they often do not have the capacity to train others and lack subject knowledge. In addition, NGOs commented tha, providing poor training to staff who already have limited capacity an, are continually overloaded greatly diminishes their ability to deliver quality servicen. Supervision and monitoring of staf and performance evaluations are

not car ied out in a comprehensive manner – it is these processes that scrutinise how much knowledge is retained from training sessions. In addition, it is difficult to provide the level of training required by some staf recruited from rural communities for them to be able to deliver services and understand the complexity of the BPHS system itself. The ability of health services staf to manage refer als, monitoring and supply systems is limited. Cultural and geographic barriers and security concerns sometimes prevent staf , particularly women, from attending much needed training sessions that are of ered.



Testimony, Kunar

A specific component which aims to build the "Capacity of health Workers" has been included in the NPP Human Resources Development Cluster.⁴⁸

The component is heavily focused on increasing the number of trained workers, opening the way for similar problems to arise. An extensive training programme that does not speak directly to the needs, levels of education and capacity of healthcare service providers will be costly and will not result in improved quality of services nor enhance the capacity of service providers. This is one of many examples where issues could have been properly addressed if civil society had been adequately consulted during the design of the npps.

The low salary of healthcare workers is a major challenge given their increasing responsibilities. NGOs find it difficult to retain qualified staff and to motivate staff to be proactive given the low remuneration.

Health workers commented that low salaries affected their ability to provide quality services to the population and often forced them to accept other better paid jobs.

ngo, herat

The lack of medicine and emergency services seems to be a common barrier to quality health services. Due to an inability to effectively distribute the funds at their disposal, there have been unexpected funding delays from the MoPH causing some health centres in remote areas to close for months at a time. This also resulting in a lack of available drugs. ngos feel that the list of drugs under the BPHS is unrealistic, as the medication is difficult to procure and expensive. Clinics often only carry a small percentage of the drugs, sometimes less than 50%, that should be available for distribution.

There is a lack of emergency services in many areas, with no anaesthesiologists or emergency doctors able to stabilise critical patients. In some areas ambulances are available at ChCs or even Basic health Centres (BhCs) but often they are only available to transport patients from the district hospital to the provincial hospital. This lack of life-saving facilities was particularly problematic for women in need of emergency assistance due to delivery complications, sick children and people trapped in areas with ongoing military operations or tribal conflicts.

Testimony, Ghor

According to the moph Strategic plan for 2011 – 2015 there was a 91% availability of standard medicines at the national level in 2010.⁴⁹

NGOs and local communities' insights suggest a significantly lower percentage. The MoPH's procedures regarding quality checks for pharmaceuticals exist but are operationally quite weak. This lack of established rules and regulations facilitates corruption within the system and an influx of fake drugs into the country that often end up in public health facilities. Another contributing factor is the diverse drug procurement procedures followed by donor agencies to the BphS. While USAID buys drugs directly and distributes them to service providers, the European Union (EU) and the WB give service providers money and then the providers themselves are responsible for the procurement of the drugs. Facilities in provinces maintained by USAID tend to have better supplies of drugs and higher quality stock.

The lack of capacity from the MoPH and the fragmented approach of the donor community have led to an uneven supply of drugs in health centres that are of varying and often low quality.



lowest cost bid selection processes adopted by donor agencies have severely limited the quality of services on the ground. the average cost per capita of the BphS is 4 – 5 uSd.⁵⁰ Competition among NGOs drives some organizations to lower their financial bid to less than 4 USD⁵¹ per capita, which has a negative effect on overall quality and community satisfaction. NGOs with extremely low cost proposals are sometimes unable to practically implement services on the ground according to their proposals. the technical capacity of the proposal is secondary to the cost, and therefore the quality of services suffers. those assessing the bids often do not have the capacity and technical knowledge to determine the impacts of the cost per capita on the quality of those services.

People's preference still lies with private sector healthcare. the private sector is largely unregulated in terms of quality of service, quality of medicine and cost. Though people claim to receive better quality of service from private doctors the quality is still low and misdiagnose is frequent. There is no functioning quality assurance system for pharmaceuticals procured and sold at private pharmacies.

People reported that they often buy their medication from backroom stores in private houses. The cost of consultation and treatment varies tremendously. The low quality of services and lack of medicine and diagnostic capacity forces many people to seek medical treatment outside of the areas where they live. Some travel to Kabul and others to foreign countries such as india, pakistan or iran. for wealthy people the cost can be absorbed. Poorer people either borrow money or wait at home and sometimes even die untreated and unnecessarily. The poor quality of services not only affects people's overall level of health but also places a burden on them economically, forcing people deeper into poverty.

Testimony, Mazar



Education

in addition to and support of Afghan mdg goal 2 on targeting universal primary education by 2020, two of the NPPs focus specifically on expanding education within Afghanistan: education for All and higher Education. The NPP that focuses on primary and secondary education has made several achievements in the past few months in terms of increases in the numbes of teachers, schools and students.⁵² the quality of education provided, however, is poor in many areas as a result of the low quality of teaching staff in both primary and secondary schools and a lack of qualified female teachers. NGOs and community members reported that an inconsistent curriculum, no accepted evaluation standards for graduation and a lack of equipment were major additional obstacles that remain despite the increased number of schools.

quality education in Afghanistan. the increase in TTCs has produced more teachers. However, only 27% of existing teachers have obtained the minimum required qualification of Grade 14 graduation. In 30 provinces less than 30% of teachers have the minimum qualification. In Daikundi, for example, only 1% of teachers have a Grade 14 qualification⁵⁴.

Furthermore, there are regular reports of students acting as teachers or people being employed as teachers who have had no training, or have only attended school themselves one grade or less above their current students, in order to compensate for the lack of teachers in the area. Female teachers are faced with barriers to their movement that limit their ability to receive training. In the areas where educational options are less, and the need for skilled professionals is greater, the quality of the teaching becomes lower.⁵⁵ Therefore, the number of teachers qualified to teach at the secondary school level will be significantly less than those who are able to teach at the primary level. Research shows that it is important to have qualified teachers at the primary level in order to build a solid foundation for a child's education career. However, the lack of teachers at the secondary level means that the opportunities to continue one's education are limited. The GoIRA aims to significantly increase the number of teachers with a Grade 14 qualification by 2014 but, given the limits on human resources and education opportunities in the rural areas, this may be an unattainable goal.

NGOs consistently stated that the lack of qualified professional teachers is a major obstacle to providing



The chronic poverty that exists in many Afghan communities means that parents often have to make hard choices regarding their children's education. Families living in poverty or experiencing financial problems often rely on their children as a livelihood strategy⁵⁷ to

Testimony, Mazar

The lack of a consistent curriculum and, accepted graduation standards contribute to uneven learning patterns across the country. Parents commented that they were disappointed with what they referred to as the absence of learning standards at schools. Across the country, students at the same level are evaluated by significantly different standards. According to MoE policy, all students from Grades 1 – 3 should automatically graduate to the next grade if they attend school regularly. Year end exams, particularly in the early Grades (1-5) are graded by individual teachers. there is an absence of a more standardized method to assess children's foundational skills in reading and math. in grade 6 there is a national test that is supposed to determine passage to Grade 7. However, there are no accepted standards as to what skills and knowledge should be evaluated. As a result, children move through the system without being able to read to a basic standards even in 6th or 7th grades. In Mazar, parents commented that they fail to understand why their children, even at the secondary school level, cannot do simple math problems and have poor reading skills. This is a particular problem for students from rural areas and those applying for places in higher education institutions. Furthermore, poor quality teaching furthers the lack of people who have the necessary skills to go on and become teachers in those areas where good teaching is most needed.

Testimony, Teacher, Mazar

The lack of equipment, textbooks and teaching manuals in classrooms limits the ability of students to learn. According to GoIRA statistics, by 200, 15.5 million textbooks were printed and distributed for primary and secondary grades - 1493 and currently 70% of students are supplied with textbooks. However, parent, in the focus group, consistently commented, that they have to purchase textbooks from the bazaar that have been sold by the teachers.

-1600⁵⁶

however, parent, in the focus group, consistently.

either provide additional income or in-home supports. Poorer families often cannot afford to buy textbooks or pay for transport, forcing them to make decisions about which children they can afford to send to school. it is often the education of the girls that is sacrificed. Low time on task and insufficient hours per school year are a major impediment to the delivery of quality education. Although Afghanistan has a six day school week, between 101 and 175 days are designated -400 holiday periods, varying according to climate zone

a shift system has been adopted. According to the moe, over 3,000 school, have three -466 shifts and some even run four shifts a day

number of shifts for students in the area because teachers supplement their inadequate teacher salaries by working second jobs during the afternoon. teachers that participated in the focus groups stated that sometimes only half an hour per subject is possible. Even for Grade 6 and above contact hours may be four hours or less⁶¹.

In addition, teaching methods were a significant concern. this was expressed by both students and

-506⁵⁹

To accommodate the growing student population,

-573⁶⁰

Some schools are unable to perform the necessary:

teachers. Teachers stated that they sometimes turn to physical sanctions due to an inability to keep students engaged or to help them understand the material. This is a poor foundation for learning.

table 5: the opportunity to learn index:⁶²

The 8 elements that need to be in place (at a minimum) for a child to learn:

1. The school year has a minimal instructional time of 850-1000 hours per year.
2. the school is open every hour and every day of the school year, and the school is located in the village or at least within 1km of the student.
3. the teacher is present every day of the school year and every hour of the school day.
4. the student is present every day of the school year and every hour of the school day.
5. The student-teacher ratio is within manageable limits, assumed to be at least below 40-1.
6. Instructional materials are available for all students and used daily.
7. The school day and classroom activities are organized to maximize time-on-task; the effective use of time for educational purposes.
8. Emphasis is placed on students developing core reading skills by the second or third grade.



The development of effective policy and its implementation and oversight is dependent upon strong co-ordination among all bodies involved in delivering education services. The lack of coordination and communication between government agencies involved in education, between ministries in Kabul and their related provincial departments and between the government and the NGO community is a major concern. The communication flow between the MoE, the MoHE and the MoLSAMD is fragmented and irregular. High turnover of staff at the Ministerial level means institutional knowledge is low. Changes in leadership at some Ministries has also slowed progress as each new minister tries to “reinvent the wheel”. Nevertheless, the MoE has made concerted efforts to coordinate better. The Human Resources Development Board, set up by MoE, also has participation of MoHE and includes key donors, United Nations (UN) Agencies and NGOs. Several working groups have been established under this board that are led by MoE departments.

The gap between the MoE in Kabul and the PED in the provinces is significant. Provincial departments are scarcely staffed and the staff often lack knowledge about current educational policies and procedures. The decentralised nature of education service provision means that the MoE in Kabul is dependant on the PED for information. Communities stated that government officials at the provincial level had little knowledge about the programmes that are being implemented in their jurisdiction which contributed to the duplication of efforts. The capacity of the MoE to maintain schools after the handover by NGO partners is limited. As a result, many of the advances that are made under NGO education projects are then lost. Well trained teachers move on and retention levels fall, contributing to a drop in education standards and the amount of communication between schools and their communities. The poor salaries, gaps in communication, lack of policy knowledge, high turnover and poor oversight facilitate widespread corruption in the system by ministry staff and teachers and principals. Part of the GoIRA plan in the next three years is to further decentralisation and train staff at the sub-national level for both administrative and financial functions. Though it is important to strengthen governance functions at provincial levels, this may exacerbate already existing problems of corruption and inefficiency, especially if the monitoring capabilities of the central government are not

Teaching methods and curriculum at higher education institutes and universities are outdated. In some universities, students are asked to copy the textbook in class as a tutorial method of learning. Laboratory facilities for professional faculties, such as engineering and medicine, are ill-equipped. In universities outside the major urban centres there may be no laboratory facilities at all. Students from the youth focus groups stated that it is possible to graduate from an engineering faculty without ever having built anything. Libraries are poorly resourced and Dari language translations of key texts are rare. Some students opt to go to private institutions which may have better facilities but not necessarily better teaching standards. In addition, the cost is higher and accreditation after graduation is an issue. The quality of instruction and resources at higher education institutes is not sufficient enough to produce a new generation of skilled professionals and academics.

Testimony, Samangan

There are not enough qualified instructors and professors in higher education institutes and universities. Many teachers at this level are not qualified or have outdated knowledge in their field. Approximately only 35% of lecturers at universities have a graduate level qualification.⁶⁴ This affects the quality of education that can be provided to university students. The Higher Education NNP proposes sending 374 current faculty members abroad for Master's and PhD training. The goal is to have more than 50% of the faculty with Master's and PhDs in three years.⁶⁵ Master's level training, however, may not be sufficient for teaching at the university level for many subjects. In most countries a PhD can take anywhere from 4 – 10 years to complete. The length of time it takes to complete a PhD and questions regarding the capacity and language skills of lecturers affect the ability of this strategy to reap substantial impact on the quality of teaching at higher education institutes in the country within the next few years.



South, areas thought to be traditionally more conservative, males expressed support for women's education. The high maternal mortality rate has been an impetus for attitudinal change. Acceptance of the fact that women need to be educated so they can provide healthcare services to other women is taking hold even in more conservative regions.



CROSS-CUTTING ISSUES

gender and local governance were chosen as cross-cutting issues for the research study. taking into consideration the unique position of women and girls in Afghan society and the hope that was vested in the last ten years to strengthen women's rights, both from an international and Afghan perspective, the research study sought to examine the level of progress that had been made in this area. The study felt it was essential to recognise the important role that local governance structures – such as CdCs, local shuras and elders – have within the community in shaping attitudes towards both external actors and interventions. the role of local decision-makers was included to ascertain how they have impeded or facilitated service delivery and how NGOs could learn from positive examples.

Awareness: Cultural and traditional barriers are still present throughout the country and act as major impediments to women's education and healthcare. However, awareness raising efforts have produced some results and these barriers have become less of an obstacle than they were ten years ago. Focus groups reported that they felt awareness among men about the importance of women's healthcare and education has risen over the last ten years. even in the east and the

Health workers cautioned that women's knowledge about basic hygiene, preventative care, ante and post-natal care and birth spacing was very low in most areas. High levels of neonatal mortality drive the level of fertility upwards and result in repeated pregnancies that place women at higher levels of risk from death at child birth. All this has a serious impact on the health of women and children in the family. Barriers to

their movement and low levels of education for women have led to isolation, poor health and disempowerment. Awareness about the dangers of early marriage is low among both men and women. In some areas families use this as a coping strategy in emergency situations to generate income. Early marriage affects the ability of girls to complete their education and maintain healthy lifestyles. It is rare that girls are allowed to continue schooling after marriage, particularly in the rural and remote areas. Married girls are often perceived as having family obligations that should leave them with little spare time for education.⁶⁶ This is one of the main reasons for girls dropping out of school as they get older.⁶⁷ A further complication is the MoE policy ordering schools to separate married girls from other students and to provide separate classrooms for them. The rationale behind the policy is that married girls may discuss inappropriate topics with unmarried girls. However, the policy applies only to married girls and not boys.⁶⁸ Given the shortage of resources facing girls' schools, the lack of female teachers and already overcrowded classrooms, this policy pushes married girls out of the educational system.

Girls giving birth before reaching maturity are more likely to experience delivery complications. They have limited knowledge about how to care for themselves and basic hygiene. This contributes to the development of serious health and nutrition concerns for women and their children, yet these are preventable.



Testimony, Nangahar

Security: Women and girls are particularly vulnerable to security threats. Following an attack, families will often send boys back to school before they allow girls to return. As a result, security incidents can have a more disruptive effect on girls' education than boys. Female professionals are vulnerable to attacks, though this seems to be more prevalent among female teachers than female healthcare workers. Female teachers are targeted and harassed not just by AOG groups and criminal gangs but also by religious leaders and local decision-makers that oppose girls' education.

Testimony, Kandahar

Women are the main caretakers within families. It is rare that women themselves are actively involved in the conflict. However, they feel and must address the impact of insecurity on the men in their families who may be belligerents, anti-government or members of the army and police. Psycho-social problems, such as depression, are common among women facing persistent insecurity.

Testimony, Kandahar

Access: Gaining access to school and completing their education is much more difficult for girls than it is for boys. In Afghanistan, the gender parity index (gpi) is 0.66 and 0.38 for primary and secondary school respectively.²⁴ In addition, the MDG goal of universal primary education and the Afghanistan MDG 3 aim to promote gender equality and empower women, with the specific target of eliminating gender disparity in all levels of education no later than 2020. One of the greatest obstacles to achieving these MDG and EFA goals is the difficulty of increasing access to education for girl students and

Poverty is a major obstacle to women and girls' access to health and education. In areas where female health professionals are only available at private institutions, women from poor families that cannot afford the fees often have to rely on dais⁷⁰ or traditional medicine for delivery assistance and other health problems. Healthcare workers interviewed during the research study commented on some of the resultant problems that can arise, such as infections, unintended poisoning and death during delivery. Cost of education is a key deterrent to enrolment, retention and access to education services. For instance, as the government is unable to meet the full costs of education, many families are unable to afford user fees at all, or user fees for all their children. Both these situations usually result in girls being forced to drop out of school.⁷¹ even when the desire is there on the part of families for women and girls in the family to go to school and seek proper medical treatment, poverty is often the determining factor. even where basic services have been established, women are not always able to access them. NGOs expressed the need for communities, and particularly local decision-makers and religious leaders, to recognise the linkage between educating women

and providing better access to healthcare now and supporting women in the community in the future. During discussions, however, both male and female community members did highlight the importance of prioritizing girls' education and vocational training to create a future generation of female professionals to act as teachers, nurses and doctors.

Testimony, Mazar

In many areas, men have become more willing to send their female family members to clinics even when there are only male doctors. In 9 of the 14 provinces included in the study women were allowed to go to male doctors. This is not the case, however, for maternity and gynaecological issues, which are the two most serious healthcare issues for women. The further an area is from an urban centre, the fewer female medical professionals are available and the less willing men in the community are to send their women to male doctors. Physical/geographical constraints in access to health facilities are a major challenge in most rural areas, where donkeys are often the means of transportation and places are sometimes completely unreachable in winter for six months at a stretch. These issues, coupled with inadequate security, reduce mobility and access for women.



Testimony, Herat

distance and the poor quality of services were cited as greater stumbling blocks to female education than attitudinal barriers that oppose education for girls, at least at the primary school level. In a recent study, 25% of participants cited distance to be a major obstacle to girls' education.⁷² In some areas, schools located more than three kilometres from the home were considered inaccessible to female students, as some respondents considered it was not safe or not culturally appropriate for their daughters to walk such a distance.

Women and girls from the rural areas are fortunate if they are able to complete high school. But they have even fewer opportunities to access higher education. In rural areas where community based informal schooling is a major source of education, little effort is made to mainstream these students into the formal education system. Families in rural areas are reluctant to send their girls to university in Kabul or the provincial capitals if they do not have relatives living there. For women in provinces where there is no university, the TTC is usually the only option. Currently, however, less than 50 % of TTCs have female dorms.

Testimony, Ghor

Human Resources: According to the BPHS staffing requirements, the current demand for female doctors is more than three times the supply in the public sector. For community midwives demand is four times the supply and for female nurses it is almost seven times the supply.⁷³ In some areas, NGOs reported that there are no midwives or trained female staff.

There are few female doctors, nurses, female health workers and skilled birth attendants/midwives. In some cases they are only present at the provincial hospital level, meaning that many women cannot access healthcare in their local areas at all unless they are allowed to see a male doctor. In rural and remote areas, the problem is double, as facilities are less likely to have skilled female health workers, and local women have more difficulty accessing health facilities.

Girls are often prevented from attending school because of the lack of female teachers. 245 out of the total 412 urban and rural districts in Afghanistan do not have a single qualified female teacher. 200 of 412 urban and rural districts have no female students enrolled in Grades 10 to 12. The majority of female teachers are concentrated in urban areas: 90% of qualified female teachers are located in the nine major urban centres (Kabul, Herat, Nangahar, Mazar, Badakhshan, Takhar, Baghlan, Jawzjan and Faryab).⁷⁴ NGOs stressed that increasing the availability of female teachers is essential to ensure that education programming is in line with Islamic standards. This means ensuring that boys and girls attend separate schools and are taught by male and female teachers respectively. To address this gap, the education for All npp proposes the use of incentives for female teachers and their families to go to rural districts where there is no female teacher. However, the lack of employment opportunities for spouses and the lack of educational opportunities for children are strong deterrents to relocation for female teachers. It is a fact that the lack of female teachers is a major obstacle to girls' education in Afghanistan. However, it should also be mentioned that, in some areas, NGOs have found that community acceptance of males teaching girl students is growing. In Khost and Paktika, females constitute approximately only 3% and 5% of teachers respectively.⁷⁵ NGOs were able to obtain community approval for males to teach girls in Grades 7 to 9. This is not, however, a long term sustainable solution to the need for more female teachers at all teaching levels.

Quality of Services: Women from rural and remote areas face discrimination at medical facilities. Commonly cited by female focus groups participants from rural areas was the frustration and anxiety they feel when they have to go to health centres at the district and provincial level. They are often spoken down to, belittled and receive little attention or are sometimes completely ignored by

service providers. language and education barriers in some areas exacerbate the problem.



Testimony, Nangahar

It is a challenge to find qualified or educated female staff in rural areas. there is a lack of gynaecologists and obstetricians to attend to female healthcare needs throughout the country. Even when women have access to female healthcare workers the quality of care itself can be quite low resulting in complications and misdiagnosis. Women with disabilities, in both urban and rural areas, expressed frustration at the obstacles they faced in getting treatment for muscle pains related to their disability. They said it was difficult to find female physiotherapists and culturally inappropriate to go to male physiotherapists. As a result, they have to endure unnecessary pain and, depending on the type of disability they have, the problem can degenerate due to the lack of treatment. In addition, female teachers are faced with barriers to their movement that limit their ability to receive training and upgrade their capacity to teach. Cultural and geographic barriers and security concerns sometimes prevent staff, particularly women, from attending much needed training

The lack of girls' schools, female teachers and the lower educational qualifications of female teachers mean that the quality of education that girls have access to is low. This is particularly the case in rural and remote areas. In addition, female students in both rural and urban areas face both a lack of, and poor quality of, educational materials and textbooks, as well as water supply and toilet/sanitary facilities.

Testimony, Herat

In areas where formal education for girls is not permitted or available they can be allowed to attend classes at the local mosque. In these situations, however, the quality of education can be low as the instructor is not always trained to teach or knowledgeable about the subject. Communities interviewed in the study commented that religious leaders sometimes disagree with girls being educated and are therefore intolerant of the girls' presence in the mosque so girls, in these situations, are only allowed to attend classes for a short time or are sent home.



Awareness: Religious leaders and shura members are key players in shaping communities' attitudes on health, education and gender issues. For example, mulahs interviewed stressed the need for health and education services to always be in accordance with Islamic principles. They specifically called for more female professionals to assist with providing healthcare and education to the girls and women in their villages, as well as separate schools. Regarding issues such as female education and reproductive health, their active participation is key to increasing awareness within the community and encouraging behavioural change. This often means that actual awareness raising work needs to be done with the religious leaders so that they are able to assist with building awareness and knowledge.

Testimony, Kunar

Security: Ensuring the security of facilities and commuting professionals is one area where local decision makers can make a significant impact. They negotiate on behalf of the community with shadow governments, armed groups, AOGs and even criminal gangs.⁷⁶ In several districts, agreements have been reached which facilitate service provision by allowing facilities to be open and staff and students to travel freely along the roads. These agreements, however, are vulnerable and sometimes unsustainable.

Few local people spoke about 'transition' and the peace process as major concerns. In most cases it was only the local decision-makers who had general knowledge of these things and saw them for the most part as larger processes going on in Kabul. Information about these processes will be handed down to the community from local decision-makers. They will play a major part in shaping the attitudes of the community, allaying their fears and creating support or dissent.

Access: Local decision-makers can play a key role in

facilitating access to services. The power that they hold within the community can be used to both further and hinder the development of the community. In some areas, people reported that the local commanders had very positive influences on the

community. For example, the Western region commanders were reported as informing people about the importance of education and mobilising them to build a school and send both their boys and girls to school. Conversely, in other districts in the region people spoke of the negative impact commanders had on the community. Examples were given of local power brokers and commanders registering their men as teachers at the local schools and using the salaries provided by the moe to support armed groups and reinforce their position and power.

These communities were left without any actual teachers to provide education. In such areas there is a clear inability on the part of the government and security forces to prevent such behaviour.

hold a number of positions in the village or community as a result of their position of power, though this has no relation to their expertise and the multiple responsibilities often mean that none are performed properly. The exercise of power by local decision-makers can have both positive and negative impacts on the community.

Testimony, Ghor

Human Resources: Local decision-makers assist with the recruitment of workers from the village or cluster level. They are able to identify potential teachers for both formal and informal education and community health workers. NGOs that do not consult with the community leadership face difficulties in implementation and jeopardise sustainability. Corruption and patronage based appointments, however, are common. It is very common for a few individuals to

Testimony, Parwan.

Quality of Services: In some rural, remote and insecure areas, local decision makers are playing an important role in monitoring the quality of services provided. According to the MoE, there are over 8,500 community education shuras that work with the ministry to ensure better quality education.⁷⁷ Some areas also have health shuras. CHWs are supposed to meet regularly with the community elders to discuss community needs. In areas where services are monitored remotely, due to difficult terrain or insecurity, local decision-makers sometimes act as another checking mechanism to help improve service quality.

Testimony, Bamiyan



AREAS FOR FURTHER WORK

Mental Health

Psycho-social problems are not being addressed adequately at health or educational facilities. there are few services provided for the large numbers of people that are psychologically traumatised. Reports of mental health problems among marginalised groups, such as women and youth, are common. Both teachers and students involved in the study stressed the fact that the ability of students to learn is hampered by mental health problems. When students are allowed to go back to school after a security incident occurs, their ability to absorb information is limited by the fear and anxiety created by the incident. Students that are unable to continue their education due to security or lack of access to services were cited as being prone to mental health problems and vulnerable to drug addiction. in addition, there is a close relationship between psycho-social problems and disability. Persons with disabilities are vulnerable to the development of mental illness, such as depression. A strong stigma against those with mental illness and a lack of knowledge about treatment and reintegration makes it difficult for those with mental illnesses to seek help. The problem is even more pronounced among women with disabilities who have a higher prevalence of anxiety and depression than men with disabilities.⁷⁸ When unrecognised and left untreated, widespread mental health problems hamper the development of healthy communities and the ability of the community to absorb assistance.⁷⁹

Donor interest in funding programmes that target persons with mental illness is low.⁸⁰ Since 2005, the BphS has included mental health services but to date these services are not provided due to insufficient donor commitment, scarce availability of adequately trained staff and training programmes, stigma around mental illness and poor follow-up, rehabilitation and integration into the community. In recognition of the extent of psycho-social problems among youth, one of the components of the Education for All NPP aims to train 4,100 high school teachers as guidance counsellors to support students academically and psycho-socially. This is an admirable goal and a service that is desperately needed in Afghan schools. the lack of human resources and low educational qualifications of teachers, however, may hinder the implementation and effectiveness of such a programme.

One of the consequences of years of conflict in Afghanistan is the large number of persons with disabilities. In addition to persons who have been disabled due to landmines or fighting, large numbers of people have disabilities due to birth defects, poor healthcare, accidents, malnutrition or preventable diseases like polio. There are also many cases of learning disabilities, mental impairments (such as autism) and multiple disabilities. There have been few baseline surveys or assessments of the disabled community and their needs in Afghanistan. The community is a diverse one with varied and substantial needs. there is a lack of attention being given to the unique needs of persons with disabilities in both the education and health sectors. the lack of transportation assistance acts as a disincentive to accessing services. there is a lack of skilled professionals trained to deal with the health and education needs of disabled people in Afghanistan. the quality of service received is low due to a lack of appropriate medicine and equipment and low levels of knowledge. Though awareness has grown within communities about the needs and rights of people with disabilities, discrimination by community members is still a major obstacle.

ngo, Wardak



one of the positive changes over the last ten years cited by focus group participants was the increased number of international and national NGOs working with the disabled community. However, community mobilisers stated that the GoIRA had little idea about the scope and needs of disabled community. Examples were provided by participants concerning the small support stipend given by the GoIRA. The GoIRA provides approximately 80 USD/year to disabled persons but the money is distributed monthly in the urban centres. Therefore, disabled people in rural areas often cannot reach the city or do not bother because their transportation costs are greater than the stipend.

A specific package of services to address disabilities was included in the BPHS 2005 and 2010 revisions. This section of the BPHS remains underfunded and scarcely implemented in most areas. Physiotherapists are supposed to be available at the district hospital level according to the BPHS staffing chart. However, they can usually only be found in provincial hospitals. As a result, access to health services is severely limited for the disabled community in rural areas.⁸¹ The limited number of trained physiotherapists and other specialists, such as orthopaedists, has meant that even this minimal requirement has not been achieved. People with disabilities included in the study consistently commented that even at the provincial hospital they were unable to find qualified professionals to assist them with their health problems. District and provincial hospitals often do not have any trained staff that can attend to the specific needs of disabled persons. Discrimination and low quality services are commonplace at the hospitals. As a result, they are forced to go to the private sector for healthcare. The cost of services in the private sector is high and unregulated. This places a further economic strain on patients seeking care who are often vulnerable to poverty and unemployment.

There were severely limited education facilities for people with learning, visual and auditory disabilities in most of the provinces. There are at least 200,000 children in Afghanistan living with a permanent disability.

Approximately 65% of disabled children have access to school.³⁷ Common reasons cited by focus group participants were lack of access to buildings, the distance of facilities and fear of harassment by students and even teachers. Teachers are ill-equipped to deal with children who have disabilities. There are few facilities that train educators to work with disabled children and few schools

that specifically cater to disabled children. In addition, parents with disabilities who want to send their children to school are often prevented from doing so because of economic difficulties. Instead, children are sent to work to support the family. Some families with disabled children do not send their children to school because they feel that the investment in their education will be wasted.

Testimony, Kandahar

Awareness within the community about the needs of persons with disabilities has grown over the past ten years. In spite of these additional obstacles, the efforts by persons with disabilities across the country to mobilise themselves in the areas of health and education were striking and included a variety of initiatives ranging from family support and youth sports groups to teacher training courses in sign language and Braille.

Disabled communities in the western region commented that, although the community is generally more aware of their problems, local decision-makers can be an obstacle. They spoke of being left out of decision-making processes at the local level. Participants said they were rarely given the chance to participate and when funds are made available to the community, though structures like the CDCs, the needs of the disabled community are not recognised.

Testimony, Herat



areas, where relevant line ministries have failed to ensure that the necessary services are put in place when people are building homes.⁸³



Migrants, Displaced Populations And

A familiar backdrop to the research across Afghanistan remains the fluid migration context. This is not a new phenomenon. Migration has historically been a key coping mechanism for many Afghans. Refugees that returned during the last decade constitute 25% of Afghanistan's population and a significant number have faced secondary displacement owing to the harsh realities of return, which includes landlessness, lack of employment opportunities, insecurity and weak access to basic service provision. In all areas of the country, internal displacement is a growing phenomenon with exponential rises in new IDP caseloads recorded. The total IDP population in the country is estimated at 485,539 persons as of 31st September 2011 and this data does not include IDPs scattered in urban and semi-urban areas. The LAS strategy has not met expectations. The rate of departure of residents has been as high as 80% in a few IASs, due to the lack of livelihoods and inadequate provision of basic services, particularly health and education in some

Testimony, Nangahar

faced with a lack of services and dwindling livelihood opportunities, there has been significant rural to urban migration in recent years. Many refugee returnees and IDPs have opted to simply squat on government and private land in urban centers and these informal settlements now shelter about 80% of Kabul's population and cover 69% of the city's residential land. These settlements receive few, if any, government services and are mainly assisted by NGOs. Yet, while the majority of returnees and IDPs living in informal settlements remain particularly vulnerable and live in situations of chronic poverty, their integration into urban areas has generally been more successful than in rural areas.



They have accessed local schools and labour markets and, despite extreme hardships, have achieved a degree of sustainability in their lives allowing them to make some progress towards recovery⁸⁴. yet, at the current rate of urbanization, and as the steady influx of returnees and idps continues, overcrowding and severe pressure on service provision will grow to untenable rates, particularly around kabul, herat and Jalalabad. By 2015, the number of urban residents in Afghanistan is expected to double. Yet municipal planning and coordination between line ministries remains extremely slow to respond to the service provision needs of these populations. Planning for and mitigating against the negative impact of increased migration needs to be a priority for the Government of Afghanistan. migratory groups are at a particular disadvantage in regard to the access and availability of services. lack of physical infrastructure, discrimination and poverty all present problems to migratory communities. They have special health needs and are more susceptible to diseases caused by natural disasters and other emergencies created by insecurity. There is a lack of mobile clinics to service Kuchi communities and those living in LASs tend to suffer from inconsistent access to basic education and health services depending on the site location. idps and returnees are sometimes unaware of which healthcare services are available in the area. Their access to services can be hampered by individuals from the local communities in the area where they are residing who feel that the increased population hinders their access to already overloaded services. Girls moving back to conservative areas face difficulty in accessing education due to cultural barriers. Returnees coming back from Pakistan and Iran tend to place a high value on education. In many of the LASs there are no schools above the primary level or the schools are not placed in safe areas. Lack of employment opportunities and poverty hinder families from sending their children to school, either because they cannot afford the cost or transportation or the loss of extra labour.

SUSTAINABILITY ISSUES

As the transition process begins, concerns are rising as to what the fate of Afghanistan will be, with 2014 just around the corner. it is doubtful that the Afghan state will be in a position by 2015 to provide basic services to all of its citizens.⁸⁵ in addition, a significant amount of the external assistance that comes to Afghanistan goes towards security. 51% of external assistance disbursed to date has been invested in security, whilst the remaining 49% has supported reconstruction and development activities across all different sectors.⁸⁶ Both the health and education sectors are heavily reliant on external funding. rapid and substantial drops in funding could cripple the health and education services across the country. Serious consequences could come about as a result. Such actions could have devastating effects on the overall development of the Afghan population, fuel uneven development across the country, increase the negative perceptions of the local population regarding the legitimacy of the government and their willingness to rely on and trust local government and increase frustration towards the international community. Sustainability of services is reliant upon sustained levels of donor funding that is delivered absent of political agendas and that directly targets the needs of the people. donors need to increase their focus on improving the quality of and access to services, make substantive developments to the human resources capacity of Afghans, support research programmes that shed clarity on the local reality and create more inclusive and transparent consultation processes with Afghan civil society to inform the development of comprehensive policy directives and strategies. Sustained donor funding must be coupled with a shift in policy and programming direction. Significant gains have been made in increasing quantity in both the health and education sectors. the BphS was an effective mechanism for rolling out the rapid expansion of primary healthcare services across the country immediately after 2001. The significant investments in TTCs and school construction have increased access to education for thousands of Afghan students. In education more focus needs to be put on learning outcomes and

standardisation, teacher retention and building teaching capacity. in health the focus needs to be on the technical capacity of service providers, increasing the skills of

healthcare workers, improving monitoring and evaluation and standardising quality assurance procedures for medicine. Outcomes and impact should be informing future policy direction rather than inputs and outputs.



Sustainability is dependent upon the development of

coherent, implementable policy frameworks that address local realities and needs. the 2010 BphS revisions have yet to be implemented, almost 15 months later. The EPHS from 2005, where it is being implemented, has shown a number of shortcomings in its design, range of clinical and diagnostic services, staff structure and drug lists. the revision of BphS in 2010 was not followed by adjustments in the EPHS. The MoPH lacks comprehensive policy frameworks and programming for major health sub-sectors such as disability and mental health.⁸⁷ instead, they have just been incorporated as components of the BPHS. The planned activities have yet to be implemented due to a lack of funding and unrealistic human resource management planning. The lack of coherence and communication within and between the ministries involved in education and other stakeholders hinders the development of an organised and effective educational system.

Policy and programming that just build upon previous policies or benchmarks without being informed by the reality on the ground create a skewed picture of the situation in Afghanistan and act as barriers to progress and sustainability. Such policies and programmes are indicative of those that are created without adequate consultation and input from civil society and communities.

Afghanistan is one of the largest recipients of international aid in the world and has been dependent upon foreign aid to sustain itself and provide services to the population for decades for over 60 years.⁸⁸ Sustainability cannot be achieved if the health and education sectors continue to be completely dependant on international aid and if that aid fails to develop the quality of those sectors. The ability of the government to absorb, disburse and monitor aid needs to be strengthened. Cost effectiveness analysis of contracting in services and the further development of internal revenue mechanisms will shed clarity on the sustainability of service delivery and allow the government to begin moving away from complete aid dependency.

CONCLUSION

Many positive impacts have been made in the areas of health and education over the past ten years. the positive developments that have been made have raised the expectations of the people for access to quality education and health services. however, progress has been uneven and heavily linked to increases in quantity not quality. to date, international investment has been too focused on increasing visible infrastructure and building the legitimacy of a government. It is imperative that future assistance is given free of political agendas and focused on the real needs of the people. There has been a drop in the motivation of the population to support initiatives in their areas. in addition, both physical and psychological insecurity has had a serious impact the ability of local people to access services and the quality of those services. Communities are becoming more pessimistic and feel less able to influence the processes that are taking place. future aid programmes should focus on substantive achievements, such as increasing the quality of services, training and standards of professionals in health and education. Adequate services are not being provided, particularly in the rural areas, and as a result there is growing dissatisfaction and disillusionment among the Afghan public.

It is important that the international community continues to invest heavily in both sectors but this investment now needs to shift focus. it needs to be redirected to strengthening the quality of services and further improving access. Significant effort needs to be placed in developing practical human resource management plans and strategies, coupled with improved training and educational opportunities and incentives for people from rural and remote areas, marginalised groups and women. The NGO community needs to increase their efforts to strengthen monitoring mechanisms in insecure and difficult to access areas in order to enhance the quality of services provided. The complexity of the security situation needs to be addressed and flexible policies adopted that speak to the variety of issues that emerge due to insecurity. A balancing act needs to occur to level the playing field between the urban and rural divide and between the insecure areas with heavy investments and the 'secure' areas that have been marginalised.

The improvements that have been made in women's health and education, though laudable, are fragile and reversible and therefore require continuous commitment to become long-term achievements. Effective and rigorous monitoring

systems and research and baseline data collection initiatives need to be implemented to facilitate programming that

recognises the reality in rural and remote areas and within vulnerable communities, such as migrants and persons with disabilities and mental health concerns.



A WAY FORWARD: RECOMMENDATIONS

Financial disbursement mechanisms at the MoPH need to be strengthened to ensure timely disbursement of funds to NGOs providing services. This will limit interruptions to service delivery due to funding gaps. MoPH needs to increase its capacity and expertise to institute strong quality control mechanisms over all imports of pharmaceuticals and medical supplies.

MoPH policy and programming needs to speak to the

reality on the ground rather than previous policies on paper. The BphS needs to provide adequate levels of funding to service providers that gives them the flexibility to respond to the geographical barriers that hinder access to remote and mountainous areas.

Stronger coordination between the MoPH, the MoE and MoHE needs to take place. The three ministries

need to work together to identify key areas of need and develop recruitment plans to fill those gaps. For example, preferential schemes should be developed for students coming from rural areas in medical training institutes to build the pool of trained healthcare staff from outlying

areas. To ensure the “brain drain” from these areas is at least staged, mandatory service in rural areas could be implemented as part of the certification process.

The development of a national curriculum and its standardised implementation across the country needs to be given priority. Curriculum and teaching materials need to be language appropriate and consistent. Monitoring of teachers’ understanding of the curriculum, the extent of its use across the country and the resultant learning outcomes for students must be incorporated into the government’s strategic planning process.

The MoE needs to prioritise the development and

Donors should adopt uniform financial and technical selection procedures so that all areas receive similar levels of healthcare assistance. Contractors need to be

selected based on the technical superiority of proposals rather than the lowest cost. An accepted province-specific minimum threshold should be established to exclude proposals that are financially unreasonable.

accreditation of teachers that are currently teaching but do not meet the minimum educational requirements. Training programmes in rural areas need to be prioritised to address the gap between urban and rural quality of education. This is particularly important for female teachers that are limited by movement restrictions. This will also be an incentive for teachers to relocate to rural areas if they know they will still be able to access professional development opportunities.



The TTC model itself needs to be revised to ensure that it produces teachers who will enter the educational system and achieve its objectives. A mandatory stage of two years and guaranteed placement should be implemented to ensure teacher retention after graduation. This would ensure that the number of graduates more accurately reflects the number of teachers entering the public school system. Lessons learned and best practices from other post-conflict countries might be useful in this respect. National standards for examination and graduation need to be implemented. These standards need to be enforced by the development of specific grading guidelines, stressed during training at the TTCs and rolled out through specific training programmes among teachers and administrators that already are in service.

Significant efforts at strengthening the horizontal and vertical coordination and consistency in the ministries involved in education need to be undertaken. The flow of information from the provinces to Kabul must be regularised. Stronger oversight and anti-corruption mechanisms need to be put in place to address inconsistency, patronage and corruption.

An extensive assessment of the scope and needs of the disabled community in Afghanistan needs to be undertaken in a coordinated effort by the MOE, Ministry of Higher Education (MOHE) and the Ministry of Labour, Social Affairs, Martyrs and Disabled (MOLSA&D). Accredited programmes for special needs education should be developed and implemented in the Teacher Training Colleges (TTCs) and higher education institutes, along with an incentive scheme which recognises the need in the community and special skills that educators who take the course would require.

The provision of organised transportation to schools in areas where they are located more than 3km from the village needs to be incorporated into the government's strategic plans.

A targeted needs assessment should be conducted which determines the academic and professional upgrades most needed by faculty at higher education institutes. Alternative options to sending faculty abroad, such as distance learning, summer or executive programmes and linkages with professional development institutes in other countries, could facilitate the simultaneous development of faculty whilst allowing the students to benefit from their newly developed skills in the short term. This would also ensure that the investment made was returned to the country.



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ENDNOTES

1. Various reports from the Government and Ministry of Public Health (MoPH) of Afghanistan put the figure at over 80% from 2010.
2. Government of Afghanistan, National Priority Programme: Education for AI, 2011.
3. See Table 4: External Assistance for Reconstruction and Development only (2002-2010)
4. ABCAR is a coordination body, based in Afghanistan, of over 100 organisations, which aims to address the humanitarian and development needs of Afghans.
5. 100% of the focus groups and regional workshops conducted throughout the country as part of the research study said that positive changes had been made over the last ten years.
6. The lack of census data in Afghanistan makes it difficult to know the exact percentage of the total population that are youth. undp, National Joint Youth Programme, Annual Report 2007, puts the figure at 68% of the population being under 25. The Afghanistan Research and Evaluation Unit (AREU) paper "From Disappointment to Hope: Transforming Experiences of Young Afghans Returning "Home" from Pakistan and Iran", (2008) claims 71% of the population is under 29.
7. A "shura" is a consultative group of men or women, often composed of tribal elders, that come together to listen, discuss and decide on issues affecting the community. They are an important cultural, social and sometimes political structure in Afghan society most commonly found at the local level. Shuras also exist at the regional, provincial, national and international level.
8. The word "Kuchi" means 'nomad' in the Dari (Persian) language. Kuchis are Pashtun nomadic people, who mainly come from southern and eastern Afghanistan. Though traditionally nomadic, many now live in permanent settlements across Afghanistan. Thousands of Kuchis, however, still follow their traditional livelihood of nomadic herding. Others have become farmers, settled in cities or immigrated. Source: minority rights group international, 2008. World directory of minorities and indigenous people.
9. For the purposes of the research study "youth" was defined as anyone under 30.
10. The gender balance of females to males across all youth and disabled persons focus groups was approximately 20/80. In the LDM focus group the ratio was significantly lower. This was mainly due to the fact that female LDMs often felt more comfortable sharing their opinions in the female only focus groups.
11. "triangulation" is a research technique that facilitates the validation of data by the application and combination of several research methodologies in the study of the same phenomenon.
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