

# UNDERSTANDING THE CHALLENGE AHEAD

## EXECUTIVE SUMMARY REPORT



## NATIONAL DISABILITY SURVEY IN AFGHANISTAN 2005



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### NATIONAL DISABILITY SURVEY IN AFGHANISTAN 2005



European Union



United Nations

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**Handicap International would like to dedicate this document to Vincent Gernigon**

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Steffen Schwarz, Regional Team Manager  
Dominique Lopez, Statistics Advisor

# Abbreviations

AFA	:	Afghanis
BPHS	:	Basic Package of Health Services
BSC	:	Balanced Scorecard
CI	:	Confidence Interval
CSO	:	Central Statistics Office
DPO	:	Disabled Persons Organisation
GoA	:	Government of Afghanistan
HDR	:	Human Development Report
Hr	:	Hours
ICF	:	International Classification of Functioning, Disability and Health
IDPs	:	Internally Displaced Persons
ILO	:	International Labour Organization
MDGs	:	Millennium Development Goals
MICS	:	Multi Indicators Cluster Survey
Mins	:	Minutes
MMDSA	:	Ministry of Martyrs, Disabled and Social Affairs
MoE	:	Ministry of Education
MoWA	:	Ministry of Women's Affairs
MoPH	:	Ministry of Public Health
ND	:	Non-Disabled Person
NDSA	:	National Disability Survey in Afghanistan
NGO	:	Non Governmental Organisation
NRVA	:	National Risk and Vulnerability Assessment
MTM	:	Master Trainer Monitor
NHSPA	:	National Health Services Performance Assessment
PPS	:	Probability Proportional to Size
PwD	:	Person with Disability
RTM	:	Regional Team Manager
UN	:	United Nations
UNDP	:	United Nations Development Programme
UNICEF	:	United Nations Children's Fund
UXO	:	Unexploded Ordnance
WFP	:	World Food Programme
WHO	:	World Health Organization

# Message

Afghanistan is a country that has faced more than twenty four years of war and two greatest armed aggressors: the Soviet invasion and international terrorism. During these trying periods, the Afghans have greatly suffered, witnessing mass murders, violence, forced migrations etc. One of the main consequences of these events has been disability of a large number of Afghans including children, women and men who have lost their limbs during the wars, by landmines and UXOs. While hundreds of thousands of Afghans were disabled by war and landmines, many more have acquired impairments from birth, inadequate healthcare, congenital disabilities, accidents or malnutrition and preventable diseases such as polio. Large numbers of people who were psychologically traumatised receive minimal services, if any. In addition, there are many people with learning disabilities, mental impairments and multiple disabilities that are yet to receive adequate attention from the international community, the Government of Afghanistan and disability organisations working in Afghanistan.

Unfortunately, in addition to these serious problems, lack of healthcare, low economic levels, lack of awareness about disabilities in society and inadequate education have isolated persons with disabilities and their families even more.

Advocating for the rights of persons with disability is one of the top priorities of the Ministry of Martyrs and Disabled and Social Affairs. The current situation and lack of possibilities in the country for persons with disabilities calls for urgent support of the Islamic Republic of Afghanistan and from the national and international community and organisations. Despite the initiatives already taken in Afghanistan, a lot has still to be done to fully integrate persons with disability into the Afghan society.

Because of lack of consolidated national data, there was no real accuracy of disability figures on which action could be taken. Therefore, the National Disability Survey in Afghanistan (NDSA) became a priority and was launched in September 2004 at the request of the Ministry of Martyrs and Disabled and Social Affairs. Information regarding the Afghan population with disabilities was essential to evaluate the extent of needs to be addressed. Understanding livelihood, social participation, coping strategies and assessing the services that were effectively available to persons with disability and how they access these is useful knowledge for the Ministry of Martyrs and Disabled and Social Affairs, as well as other partners to define a National Disability Strategy. Such a strategy, based on scientific knowledge, aims at designing and coordinating effective public policies in a context of limited resources.

I am extremely pleased that during the crucial time and with landmines affecting Afghans every day this survey is now scientifically and technically completed. I am confident that the results and findings presented here will be of great value to all decision-makers working in the field of disability in order to define programmes and policies that are relevant, efficient and sustainable.

Once again I would like to thank Handicap International who has carried out this study and I wish more success for HI. The Afghan nation will never forget the support of anybody in this critical situation in Afghanistan.

**Hajji Sayed Mohammad Hadi "Hadi"**  
Deputy Minister of Martyrs and Disabled and Social Affairs

# Preface

The National Disability Survey in Afghanistan was undertaken by Handicap International on behalf of the Government of Afghanistan and supported by a number of donors interested in obtaining reliable information that could assist the government and relevant stakeholders to target limited resources addressing the needs of people with disability throughout the country. It is with this in mind that the NDSA was developed and funded. Information is key for the development of policy and programme activities and is essential for continued advocacy and support of disabled persons globally.

The fieldwork by the NDSA team was completed under extreme security situations and harsh conditions. The work of drafting the results of the research has now been completed. This long awaited process, supported by those within the disability sector and the donor community, is ready for use. This executive summary gives an overview of the entire research project that is available in supplementary research chapters focusing on specific issues of education, health, employment and gender and will be invaluable for programme planning and advocacy activities.

Although the NDSA prevalence rate for disability may be perceived as lower than expected, I believe that when compared to those prevalence rates of other nations impacted by landmines and recovering from conflict, the Afghanistan figures will be among the highest. I also believe that as we push forward with programme activities and advocacy through our government partners, the prevalence rates will begin to increase as the availability of services, better healthcare, awareness of disability causes and issues along with greater inclusion of people with disability, will bring about a marked change in the survival of disabled persons and the reporting of disability in Afghanistan.

I have been part of the NDSA survey team from the very beginning. I am proud of the work put forward by my dedicated colleagues and believe that the dissemination of this important information will assist us in moving forward the Mine Ban Treaty obligations for victim assistance and marking progress within the context of “Addressing the rights and needs of mine survivors and other persons with disabilities: The Government of the Islamic Republic of Afghanistan’s objectives and plan of action for the period 2006-2009”.

Information is key to raising awareness and advocating for the rights and dignity of all people, including those people with disability throughout Afghanistan.

**Susan Helseth**  
Victim Assistance and Mine Risk Education Coordinator  
UNMACA/UNICEF

# Foreword

For nearly twenty five years Handicap International has been involved in support to persons with disabilities worldwide, promoting their rights and welfare, whatever the situation they are confronted by. With regards to Afghanistan, our organisation started its activities of rehabilitation inside the refugee camps established in Baluchistan in 1985, by producing wheel chairs, prosthesis and orthotic devices, and training Afghan refugees in physiotherapy in Quetta, Pakistan. Following this, a project was launched and continued for several years on Afghan territory, in the town of Herat. It was sadly suspended following the death of Vincent Gernigon, a young and dedicated physiotherapist, in a military clash between resistance and government forces in 1989. I would like to dedicate this work to him, his family and friends.

In 2001, Handicap International resumed its activities in Afghanistan by setting up offices and projects in different provinces: Kabul, Herat, Kandahar and Ghazni. Several activities have been developed since then, ranging from: physical rehabilitation services, outreach programmes, community based rehabilitation, awareness and sensitisation activities and training of physiotherapists, to mine risk education projects and setting up small Explosive Ordnance Demolition teams. With the NDSA, Handicap International has taken a new step towards improving understanding of all stakeholders and bridging the gap of knowledge about the situation of persons with disability in Afghanistan. The NDSA provides insights into the social, cultural and political mechanisms that make persons with disability and their families one of the most vulnerable groups in the country.

The NDSA was launched in 2004 to provide stakeholders with the necessary knowledge about persons with disability in order to enhance the effectiveness of their action. The overall aim was to design and define disability programmes in Afghanistan through a better identification of the needs as expressed by the people themselves.

It has been a challenging decision to launch a programme that required sending teams of surveyors to a country where security remains a constant concern.

When the survey started, the Government of Afghanistan was in the process of setting the basis for rebuilding public services that had collapsed. The main challenges in order to meet the population's essential needs, were to restore access to healthcare, water supply and sanitation, housing, education and employment. However, despite the general belief that "everything needed to be done upfront", our experience in the field of disability made us aware of the necessity to prioritise actions in order to define a sustainable strategy for persons with disability, based on relevant knowledge and understanding of a complex situation. Our aim was to ensure that the requirements of all persons with disabilities would be taken into consideration and incorporated into the proposed set of actions.

I would also like to express my gratitude to Dr Frederic Tissot, who supported the project right from the very beginning and understood the importance of such an endeavour. He has met with an unfortunate accident in Haiti, after leaving Afghanistan and is currently in France. The entire team has appreciated his contribution to the NDSA.

I hope that the present document will prove to be a relevant and inspiring source of information for policy and decision makers, within the government, the donor community as well as the humanitarian and development actors: all those who are committed to help persons with disability gain self respect and find a rightful place in the Afghan society.

**Jean-Baptiste Richardier**

Executive Director , Handicap International, Lyon - France

# Introduction

As the process of reconstruction is currently going on in Afghanistan, after over two decades of conflict, the risk of the emergence and widening of the gap between those who benefit in priority from peace and reconstruction and the marginalised groups of the Afghan society is becoming a serious concern. Afghans with disability are one of these vulnerable groups, with specific needs and a demand for a rightful place in the new republic.

As in other countries, persons with disability in Afghanistan do not make up a homogenous group. Social perceptions of the causes of disability lead to social acceptance or exclusion from the community. The physically disabled, and more specifically those disabled from war or its consequences (landmines and UXOs), are a fairly visible group: socially accepted and valorised, these persons with disability are mostly men and have a strong political voice. The picture is grimmer for women and persons with mental disability. The cause of the disability being more difficult to identify, lack of knowledge and awareness lead to social exclusion and rejection. In a context where resources are scarce and ensuring daily survival is a constant challenge, the 'hidden disabled' are not the priority.

The National Disability Survey in Afghanistan, or NDSA, was commissioned to better grasp the various facets of disability in the country: to better understand those that were visible, and to bring to light those that were often not visible. It aimed to present a comprehensive view of the disability picture in the country, a picture that could, in turn, contribute to a better understanding and recognition of the social diversity of persons with disability in Afghanistan. Some findings presented in this report were in line with the outlook of the various partners, others were more unexpected and forced a different approach to reality. The identification of the specific needs and the understanding of the exclusion mechanisms that slowly but surely marginalise a large part of the population with disability, and taking measures to prevent these, are the first steps to mainstreaming and empowering all persons with disability. Knowledge of the social, cultural, physical and institutional barriers is crucial to fight exclusion. The NDSA attempted to answer the basic question: why and when does impairment become disability? What are the various mechanisms that trigger exclusion and how can this be prevented in the long run?

The NDSA aims to bridge the knowledge gap regarding the number, health, educational and employment situation, livelihoods and social integration of Afghans with disability. Such knowledge is imperative to define and implement a disability strategy. The results, presented briefly in the present Executive Summary Report, attempt to provide strategic planners, administrators, organisations of persons with disability, NGOs, UN agencies and others the knowledge and tools needed to push forward the agenda of persons with disability in Afghanistan and enable them to gain their rightful place.

The Executive Summary Report presents a brief view of the methodology and results of the NDSA. The first section looks at sampling methods and field realities. The following sections look at the major findings related to the main fields of the survey: health, education, employment, and livelihoods. The last section relates to social participation and marriage.





# Survey Methodology

## From Sampling Requirements to Field Realities

The methodology that was followed for the NDSA was a random, probability proportional to size (PPS), three step sampling. A number of steps were taken in order to ensure that the sample selected was representative of the Afghan population. Following the defined sampling procedure helped ensure that the conclusions made for the selected sample were valid for the entire Afghan population.

### Why Select a Sample?

Choosing a representative sample has many advantages in comparison to other types of survey or a census, for various reasons:

- It is close to impossible to include everyone in terms of time, distances and resources (human and financial).
- Including everyone is not necessary: statistically the same results can be obtained from a small part of the whole.
- Using a sample also allows an in-depth analysis of specific issues, which a census does not.

Any PPS sampling frame is based on two principles:

- Everyone has an equal chance of being included in the sample.
- The sample selected has the characteristics of the parent population in order to avoid bias.

### Defining the Sample Size

A national survey on disability requires a sound sampling methodology that allows the establishment of valid prevalence rates at the national level. As a result the conclusions made for the sample would be relevant at both, the national and sub-national levels. Our partners at Johns Hopkins Bloomberg School of Public Health carried out the necessary calculations and defined the number of households that needed to be surveyed in order to obtain the rate of prevalence with the wanted accuracy.

These calculations gave us the number of households according to three factors;

- The rate of prevalence of disability, estimated at 6%;
- The confidence interval;
- The level of precision chosen.

The representative sample selected consisted of 5250 households<sup>1</sup>, which represented around 39,000 persons, with a confidence interval of 95% and a precision of 15%.

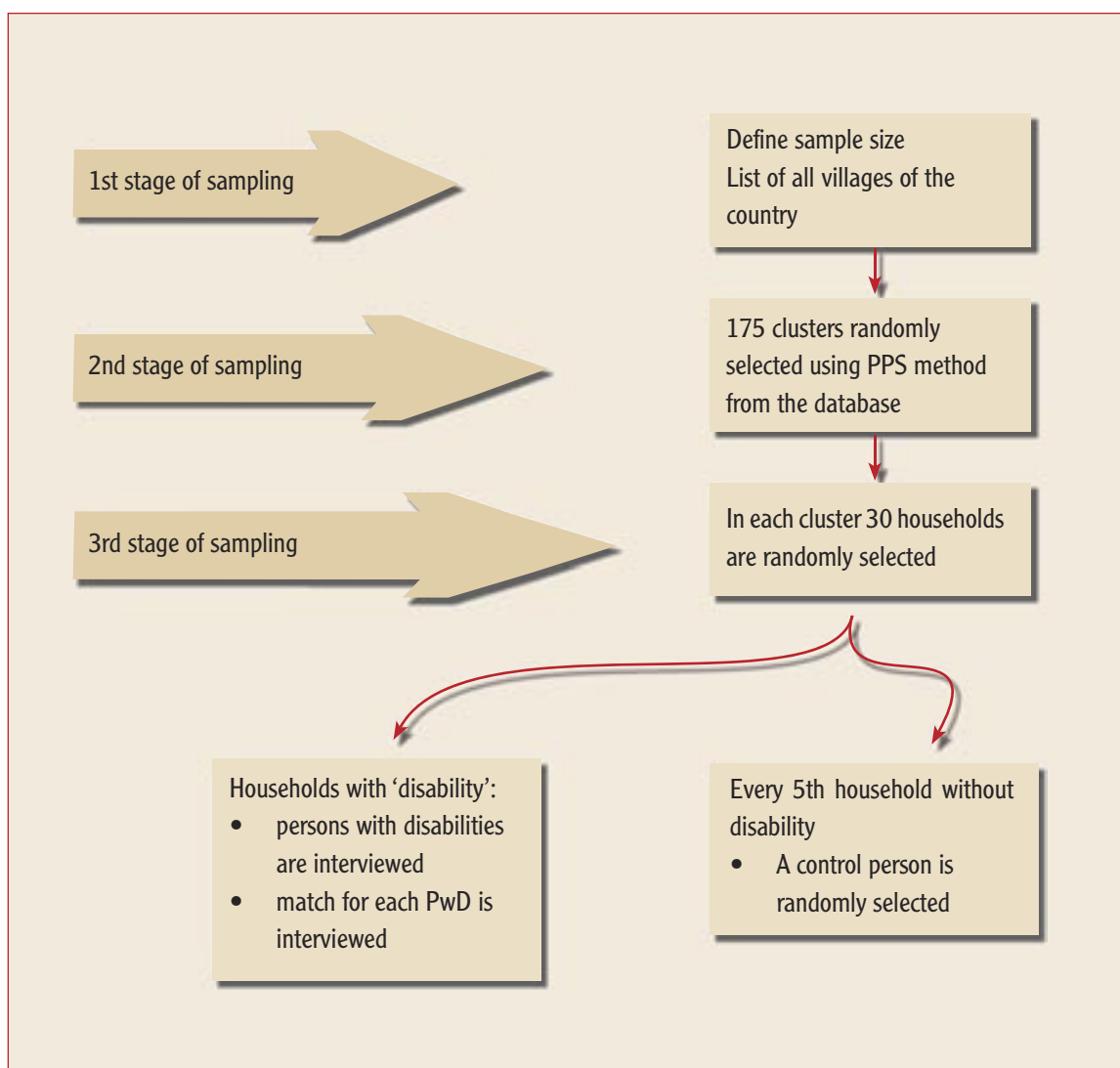
### Following the Sampling Stages

The NDSA is a probability proportional to size (PPS), three-stage random sample survey. This means that at each stage of the sampling process each household had an equal chance of being selected. This in

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<sup>1</sup> For the NDSA, the household is a group of people who may or may not be related by blood or marriage, who live under the same roof or within a same compound, who take their meals together or in small groups (one kitchen in the house), who put together part or all of their income for the needs of the group and who are dependant on the authority of the head of the household for all the expenses entailed. You may come across 'uni-personal' households that consist only of one person: for our survey this concerns the situation where the interviewee lives alone. The definition adopted is similar to the one adopted by the CSO for the pre-census of 2004, by NRVA in 2003 and 2005 and by Johns Hopkins household surveys.

**Figure 1. Sampling Stages of NDSA**



turn ensures that the sample selected for the survey had approximately the same characteristics as the population of the country.

### The Control Groups

In order to understand the living conditions and coping strategies of persons with disability it was necessary to compare their situation to those who were considered less vulnerable. This, in turn, helped understand whether a given problem was specifically linked to disability, or whether the family or the community as a whole shared it. Two types of control groups were surveyed:

**The Match:** Within the household of a person with disability the surveyors had to interview a member without disability, who was close to the former in terms of sex and age. Interviewing the in-household match allowed comparisons between the situation of a person with disability and one without disability within the same household.

**The Control:** A control person was randomly selected from every fifth household where there was no person with disability. This made possible the comparison between the situation of a person with disability and one without disability from a “non-disabled” family. This allows a comparison, not only at the individual level, but also between households.

## Limitations Faced

**Non-coverage:** Four clusters out of 175 (2.2% of the overall sample) were not surveyed because of security concerns for the teams. Extrapolation of results based on the province level analysis has been carried out for these clusters.

**Kuchis<sup>2</sup>:** The nomadic population is difficult to include within a household survey. However, whenever a Kuchis settlement was situated within the selected cluster, it was included in the sampling process.

**Refusal rate:** Refusals were very few and almost all in urban areas. When a head of household refused to be interviewed it was replaced by a 31st household in the cluster. The rate of refusal was less than 0.3%.

## Developing Relevant Tools

The NDSA questionnaire was developed over a period of 5 months with inputs from a number of partners within Afghanistan and around the world. This tool consists of various sections:

- A checklist;
- A household questionnaire to collect information about all the members of the household;
- A screening questionnaire that consists of 27 questions and that helps detect the presence of persons with disability within the household;
- An adult questionnaire that is used for the person with disability, the in-household match or the control when the interviewee is 15 years of age or older;
- A child questionnaire that is used for the person with disability, the in-household match or the control when the interviewee is 14 years of age or under.

The questionnaire itself is composed of different units covering elements that help understand the opinions and perceptions of persons with disability regarding the following topics:

- Family and demographic characteristics;
- Health conditions and accessibility to existing services;
- Education;
- Labour market, job accessibility, unemployment and underemployment;
- Livelihoods, level and sources of income;
- Social networks and participation.

Various other documents were also elaborated for the survey on the field:

- A detailed surveyor's manual;
- A field process document;
- A sampling process document.

## Recruitment and Training of Teams

The Master Trainers/Monitors (MTMs) were recruited among the staff of the partners of the NDSA according to qualification requirements (school leaving). The training was a 24-day intensive session in Kabul. They had to pass a test at the end of the training that would determine whether they would participate in the survey or not. The MTMs carried out the survey in the Kabul region. The twelve MTMs then conducted the two-week training in the other regional centres all around the country for around 200 surveyors, both men and women.

*The Master Trainers/Monitors (MTMs) were recruited among the staff of the partners of the NDSA according to qualification requirements (school leaving). The training was a 24-day intensive session in Kabul*

<sup>2</sup> Kuchi in Persian means "those who move". Afghan nomads comprise two large groupings. The Western group comes from the desert in the South West region of the country. They are largely from the Durrani tribes. The Eastern group drawn from various Ghilzai tribes associated with better watered, lush grazing grounds of the East region of the country. In Richard Tapper "Nomadism in Modern Afghanistan: Asset or Anachronism?" in Louis Dupree and Linette Albert (Eds.), *Afghanistan in the 1970s*, New York, Praeger Publishers, 1974: 128-9

A variety of subjects and fields addressed during the first week of training by the HI occupational therapist, physiotherapist and psychologist were:

- Concept of disability, discussing definitions;
- Physical and sensorial disabilities;
- Mental disabilities;
- Children with disability;
- Interviewing techniques (attitudes, vocabulary, respect).

## Carrying out the Fieldwork

Each region was supervised by a Regional Team Manager (RTM), who was seconded by two Master Trainers/ Monitors (MTM). These persons were in charge of the complete field organisation: contacting authorities, recruiting and training surveyors, organising transport, accommodation and security as well as carrying out the quality check for the data.

*Each region was supervised by a Regional Team Manager (RTM), who was seconded by two Master Trainers/ Monitors (MTM)*

## Ensuring Quality

The most important aspect of data quality checking was to ensure that quality control was carried out at all stages of the survey. The first check was done in the cluster by the MTM in charge. This ensured that the missing information was minimal. The questionnaires were also checked for coherence by the RTM and the NDSA Project Manager before entering in the database. Lastly, there were random checks of selected villages in each area to ensure that the data collected was valid. In at least 6% of the clusters, 5 – 10 households surveyed were re-checked by independent persons, not having participated in the survey.

## Data Processing and Analysis

The data was processed using scanning software, Teleform Verity®. This ensured quick data entry while minimising the human errors of a manual process. However, this software required a high level of technical knowledge in order to utilise it efficiently. One of the main problems was the impossibility of recognising the Dari and Pashto scripts, which delayed the printing of the completed questionnaires. The scanning process started in Kabul, in the WFP premises, which hosted the only copy of the software. Due to unavailability of the equipment, the work was finished in New Delhi, India where the Handicap International South Asian Regional Coordination Office is based.

The data analysis was carried out using the SPSS® software. A series of reports were produced as and when the data cleaning was completed and in view of the demands from the various stakeholders. These reports present the basic indicators regarding each section of the questionnaire as well as sex-disaggregated data and analysis according to the different variables included in the questionnaire.

# Prevalence and Typology

## Overall Profiles of Afghans with Disability

**H**ow many Afghans have some form of disability? It is extremely perilous to answer this question without first defining ‘disability’ for our purpose. In addition to conflict in the past, bad health care and general political instability, there are also strong beliefs of what these rates are, according to the various partners working on the field as well as donors and international agencies. It is interesting to note that internationally there have been attempts to set a standard for prevalence rates, which have so far been unsuccessful. “In 1981 UN/WHO studies estimated that on an average 10% of national populations are disabled. However in 1992, this estimate was modified to 4% for developing countries and 7% for industrialised countries.”<sup>3</sup>

This section explains how disability is defined in the NDSA and in view of the objectives. It also argues that establishing any rigid definition is futile. Disability is a continuum, ranging from very severe difficulties in functioning to very mild forms. Where we choose to put the threshold, depends closely on the context and the aims of the exercise.

### Definitions of Disability

The variations observed in prevalence rates across countries can be explained by a number of factors. The social beliefs and stereotypes related to disability vary, not only in terms of culture but also depending on the level of awareness and visibility of different types of disability. Lastly, the decision to include certain forms of disability is closely linked to diverse aspects of policies that are being implemented. Some surveys find very high prevalence rates since they include various conditions (i.e., chronic illness) in the definition of disability.

The NDSA screening was based on the International Classification of Functioning, Disability and Health<sup>4</sup> (ICF) as well as the capability approach used by the UNDP Human Development Report (HDR). These frameworks help to look, not only at the impairments, but also at the activities and participation of individuals in order to understand the disabling situation. For this survey the following definition was elaborated in line with the aim of providing knowledge and policy guidelines:

“Disability is the condition that results from the interaction between an individual impairment in functioning and the community and social resources, beliefs and practices that enable or prevent a person from participating in all spheres of social life and taking decisions that are relevant to his/her own future.”

### Prevalence Rates

The prevalence of disability is the proportion of persons in the overall population that is considered to be disabled. This rate is generally expressed as a percentage of the parent population; in this case the whole population of Afghanistan. However, before presenting the tools through which this was done, it is important to state that this rate changes and evolves and is closely linked to a number of factors:

- Definition of disability and the choice to include/exclude certain forms of difficulties;
- Level of awareness that exists within a given social and cultural context;

*The variations observed in prevalence rates across countries can be explained by a number of factors. The social beliefs and stereotypes related to disability vary, not only in terms of culture but also depending on the level of awareness and visibility of different types of disability*

<sup>3</sup> MITRA S. (2005), “Disability and Social Safety Nets in Developing Countries”, *Social Protection Discussion Paper Series*, No. 0509, May 2005, Social Protection Unit, Human Development Network, The World Bank, Washington D.C.

<sup>4</sup> World Health Organization (2001), *International Classification of Functioning, Disability and Health*, Geneva.

- Beliefs and expectations of what these rates should be within a given context;
- Formulation, wording and manner in which the questions are asked;
- Underestimation of certain kinds of disability that may be hidden within a given culture (mental disability is often more difficult to detect adequately).

As a result, prevalence rates fluctuate over time and according to the definition and typology that is used to establish it.

Lastly, it is essential to differentiate between “the incidence (the number of persons who were born or made disabled), and the prevalence rate (the number who survive)”<sup>5</sup>. The NDSA did not ask questions regarding incidence of disability within the family.

### Setting a Threshold: What does Disability Mean in a Given Context?

Bearing these facts in mind it becomes important to look at disability as a continuum that ranges from very severe difficulties to almost no difficulties. Where the researchers, policy makers or other stakeholders decide to set the threshold depends upon their aims and objectives.

#### The Screening Questionnaire: 27 questions

For a survey on disability that aims at establishing prevalence rates, as well as looking at the living conditions of persons with disability, researchers needed to devise a screening methodology that was not based on the judgment of one or more surveyors. The questions were determined according to different sections: physical, sensorial, psychological, intellectual and relational. These questions related to the concept of what is ‘disabling’ to lead a fulfilling life within the community and in society. The designing of questions that were not stigmatising and that were presented in a non-threatening manner for the interviewees and their families was a difficult task.

For the NDSA the focus was placed upon the persons having very severe difficulties in everyday functioning, detected through a screening questionnaire: 27 questions grouped in 5 sections. The elaboration of the various sections of the screening tool of the questionnaire was long and required consultation with a number of specialists. Each disability was screened through a specific question, studies having shown that the aggregation of several disabilities into one question leads to a serious underestimation of certain types of disability.

#### Looking at Ability to do Things: 46 Questions on 9 Dimensions

The NDSA analysis was based upon the persons with severe difficulties who were detected through the screening questions explained above. However, another possibility can be considered by using the section of the questionnaire that looks at the ability to do things. This was part of the health section and was not used for screening but it gives essential information that can be used to provide a different view of prevalence. This section consisted of 46 questions that were grouped into 9 dimensions for analysis:

- The ability to take care of oneself on a day-to-day basis;
- The ability to contribute to tasks within the household;
- The ability to move around and contribute to tasks outside the house;
- The ability to communicate with other members of the family and the community;
- The ability to interact and have social relations with people;
- Intellectual and memorisation abilities;
- The ability to have coherent individual behaviour;
- The absence of depressive symptoms and signs of trauma and other psychological problems;
- The absence of fits, seizures and signs of epilepsy.

<sup>5</sup> COLERIDGE P. (1998), “Development, Cultural Values, and Disability, The Example of Afghanistan”, paper presented at the conference *Disability issues: Global Solutions and the Role of Community-Based Rehabilitation* Queen’s University, Kingston, Canada, March 5-6, 1998.

*It becomes important to look at disability as a continuum that ranges from very severe difficulties to almost no difficulties. Where the researchers, policy makers or other stakeholders decide to set the threshold depends upon their aims and objectives*

On each dimension the answers of respondents were rated from ‘very severe difficulties’ to ‘no difficulty’. As a result, the higher the score on each dimension, the higher the level of difficulties the persons faced on the given dimension.

## Results regarding Prevalence Rates

The prevalence rate presented in this report and used for analysis, is based on the persons detected through the screening questionnaire and who have severe difficulties in everyday functioning.

The prevalence of very severe disability identified by the screening tool of the survey stands at 2.7% ± 0.2% (CI 95%). This represents a population between 550,000 and 643,800 Afghans based on Ministry of Public Health Population estimates<sup>6</sup>; or a population between 747,500 and 867,100 if one considers United Nations Population Fund estimates<sup>7</sup>. Analysis based on the number of households, shows that on an average, 1 out of every 5 households has at least one person with disability.

This prevalence rate of 2.7% is in line with estimates that have already been put forward by the government as well as other organisations working in Afghanistan:

**Table 1. Prevalence Rates According to Various Surveys**

Sources	Year of Survey	Prevalence Rate
UNDP/UNOPS <sup>8</sup>	1991	3%, 700,000
MICS (Multi Indicator Cluster Survey) <sup>9</sup>	2003	2.5% for children under 5 3% for persons between 7 and 17
NRVA (National Risk and Vulnerability Assessment) <sup>10</sup>	2003	2% for physical disability 1% for mental disability
NDSA	2005	2.7% for overall population

### Looking at the Continuum: Where do we Place the Threshold?

If disability is seen as a continuum of difficulties in functioning, ranging from very severe to mild, then the prevalence rate mainly depends upon where we choose to place the “cut off” or the threshold. As a result, persons falling within this limit will be considered disabled.

However, even though the NDSA estimates the proportion of the Afghan population that urgently needs to be targeted by public policies and programmes to be at 2.7%, the prevalence rate will increase according to the inclusion of persons having less severe difficulties. As the understanding of disability, as well as the provision of basic services improve, this additional proportion of persons will need to be taken into account, thus increasing the prevalence rates.

*Even though the NDSA estimates the proportion of the Afghan population that urgently needs to be targeted by public policies and programmes to be at 2.7%, the prevalence rate will increase according to the inclusion of persons having less severe difficulties*

<sup>6</sup> Based on total population estimate of 22.2 million according to *Afghanistan Health Facts Sheet 2003-2004*, Ministry of Public Health finalised November 2004. Official estimates from Ministry of Economy-Central Statistic Office are not yet available.

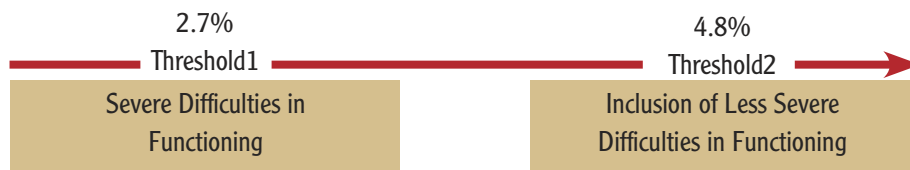
<sup>7</sup> Based on total population estimate of 29.9 million according to United Nations Population Fund *State of World Population 2005 Report, The Promise of Equality Gender Equity, Reproductive Health and the Millennium Development Goals*, September 2005.

<sup>8</sup> UNDP/UNOPS: “Comprehensive Disabled Afghan’s Program: Integrating Disabled and Marginalised People in Afghanistan”, *Journal of Mine Action*, Fall 1999, vol. 3, no. 3.

<sup>9</sup> Multi Indicator Cluster Survey, *2003 Report*, Ministry of Education, UNICEF and CSO.

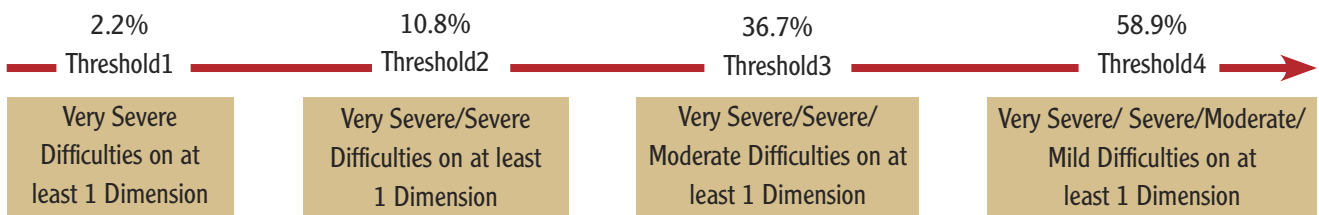
<sup>10</sup> Ministry of Rural Rehabilitation and Development, Vulnerability Analysis Unit, *Report on Findings from the 2003 National Risk and Vulnerability Assessment in Rural Afghanistan*, December 2004, [www.mrrd.gov.af/vau/NRVA\\_2003.htm#WFP](http://www.mrrd.gov.af/vau/NRVA_2003.htm#WFP). Accessed: November 2-2005.

## Prevalence Threshold with Regard to the Screening Questionnaire: 27 Questions



## Prevalence Thresholds with Regard to Abilities in Everyday Functioning: 9 Dimensions.

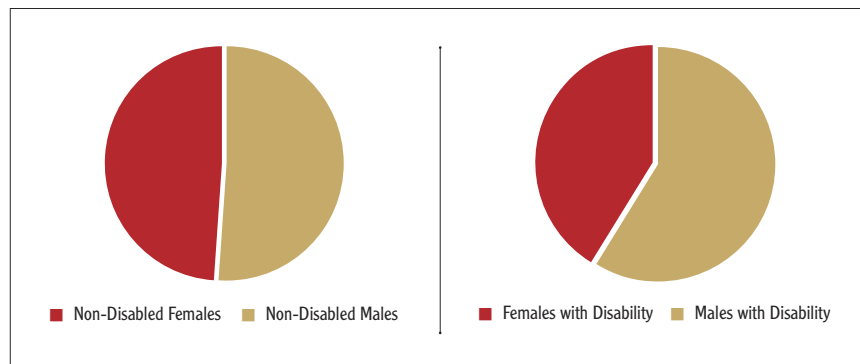
If we consider answers to the health questionnaire, according to the 9 dimensions defined above, the threshold can be put at various levels of severity of limitations. One option is to take into consideration the answers 'very severe difficulty or inability' to any one of the dimensions. In this configuration, the rate of prevalence is 2.2%. If we add people with the score of 'severe difficulty' to any of the dimensions, the rate of prevalence increases to 10.8%. Then, if we add people scoring a level of 'moderate difficulty', the rate becomes 36.7%. Finally, if we add people with the score of 'mild difficulty' to any of the dimensions, the prevalence rate becomes 58.9%. In other words, in the latter situation people with 'no difficulty' are only 41.1%!



## An Over-representation of Males among Persons with Disability

The first conclusion that we can draw regarding the overall profile of Afghans with disability is that there are (significantly) more males than females.

Figure 2. Sex-Ratio of the Non-Disabled and Afghans with Disability



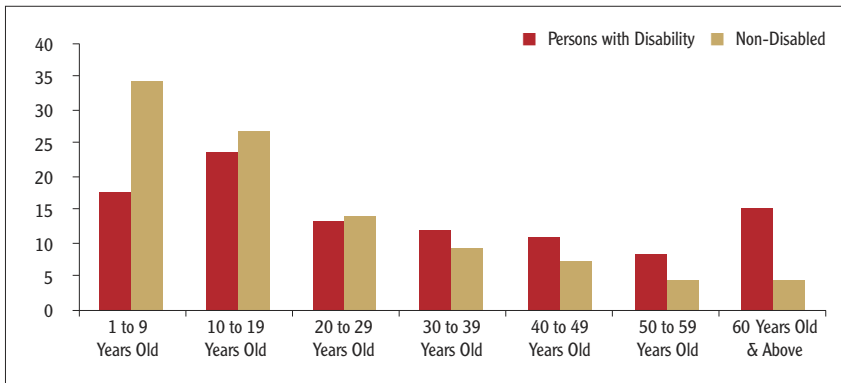
It is important to note that in the overall NDSA sample, the male-female ratio of the non-disabled is 0.95 (958 women for 1000 men). In the sample of persons with disability the ratio is 0.70 (700 women for 1000 men). This shows an under-representation of women that can be due to several reasons: high visibility of the physically disabled who are mostly men, as well as stigmatization of other forms of disability, especially mental, that are more prevalent amongst women. Another explanation is that women have less severe difficulties, so they do not fall into the 'very severe' category. This will be discussed in the following sections of this report.



## The Age Distribution of Persons with Disability is Quite Different from that of the Non-Disabled Population

The majority of persons with disability are in the 0 to 14 years age group. The Afghan population is young; 50.2% people are under age 15<sup>11</sup>. However, compared to the total, the proportion of persons with disability under age 15, or even under age 20, is lower than the same proportion in the age group above 45.

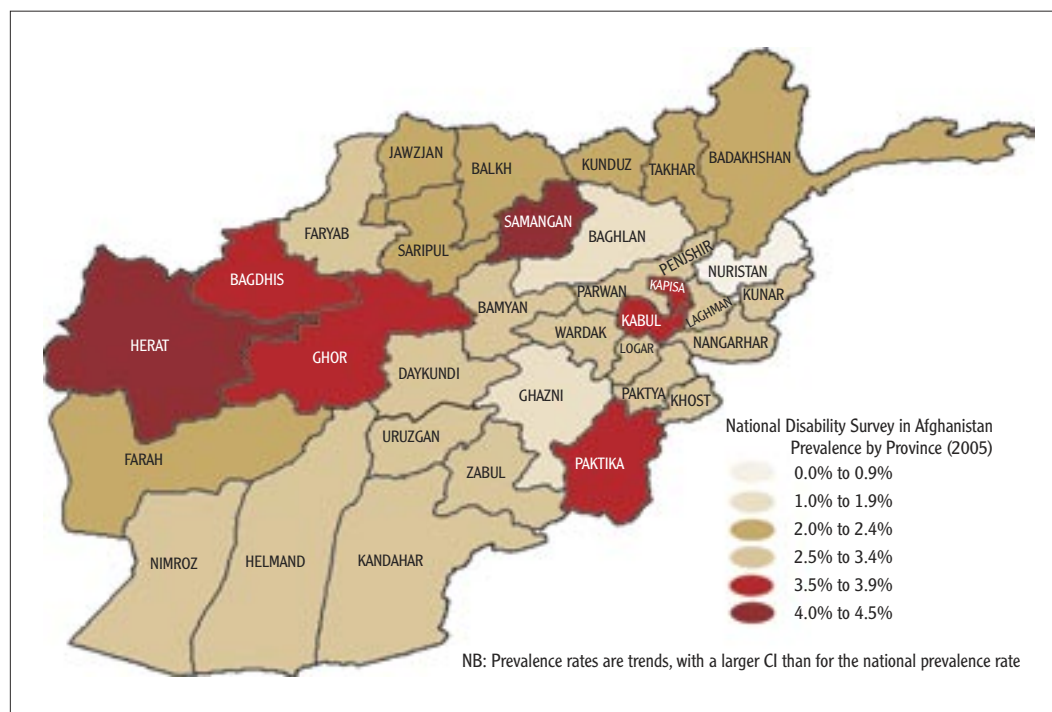
Figure 3: Typology According to Gender and Age



In other words, Afghans with disability are under-represented in categories under 20 years age and over-represented after the age of 35. The proportion of persons with disability under the age of 25 in the total disabled population is less than the same proportion in the overall sample. The gap is higher for the youngest and diminishes with increasing age. The situation is almost at equilibrium for the 25-34 age category.

The proportion of persons with disability is high after age 45, and even higher after age 60. This was found to be a statistically significant result. When people survive until the age of 60, the probability of becoming disabled is high: 15% of the persons with disability are older than 60, when this age group represents less than 5% of the overall population.

Figure 4: Rate of Prevalence by Province (Trends)



<sup>11</sup> UNDP (2004), "Security with a Human Face: Challenges and Responsibilities", *Afghanistan National Human Development Report*, Kabul. Data quoted are from the MICS, 2003.

The proportion of persons with disability is not very high in the earlier stages of life. This can be explained by various reasons. It is probable that certain forms are not yet detected at an earlier age. Furthermore, bearing in mind the infant mortality rate in the country (115/1000 live births)<sup>12</sup>, that ranks among the worst worldwide, children with disability or those who become disabled at an early stage are more vulnerable and have lower survival rates than non-disabled infants.

More than half the persons with disability are in the Central and Western areas. This can be explained by the presence of 2 highly populated cities in these areas, i.e., Kabul and Herat. The NDSA results also show that the proportion of persons with disability is higher in Central, Western and Southern areas and above the national average prevalence rate. On the other end, in the Eastern, North Eastern and North Western areas, the proportion is below the national average.

It is challenging to understand what lies behind these differences, as it is often a combination of individual, social and political factors, as a result of which, certain regions have high proportions of Internally Displaced Persons (IDPs) who moved during various conflicts. The availability and stability of health services could also result in a higher prevalence rate linked to better health care (so persons with disability have better chances of surviving through illnesses and accidents) as well as better detection.

*More than half the persons with disability are in the Central and Western areas. This can be explained by the presence of 2 highly populated cities in these areas, i.e., Kabul and Herat*

## Looking at the Typology of Disability

It is important to bear in mind that the results presented concern that 2.7% of the population who were detected as having severe difficulties in the screening questionnaire. This choice has been made mainly because the GoA and other stakeholders are targeting on priority basis persons with severe impairments. It is therefore essential to look at the typology and the profile of this population. The typology, like the definition of disability, was based upon difficulties in functioning and was devised after extensive discussion with persons with disability, partners and experts working in the field.

### Determining Typology: The Various Sections of the Screening Tool

The following disabilities were included in the screening tool of the NDSA. All questions were focused on the ability or difficulty to function in everyday life. The various sections were defined according to a wide range of criteria.

#### Section A: Physical and Sensorial Difficulties

- Lack part of/entire member(s) or functions of the body;
- Difficulties that impede movement and mobility;
- Visual impairments;
- Hearing impairments;
- Speech Impairments.

#### Section B: Intellectual and Learning Difficulties

- Later/slower speaking patterns compared to other members of the family;
- Later/slower walking, mobility development compared to other members of the family;
- Behaviour that does not correspond to the given age (child behaving younger than age).

#### Section C: Behavioural and Psychological Difficulties

- Difficulty or impossibility in expressing needs, using language that no one understands;
- Difficulty or impossibility in being with people who are not familiar;
- Difficulty or impossibility in keeping still/ staying in one place;

<sup>12</sup> UNDP (2004), op. cit.

- Difficulty or impossibility in keeping quiet, talking all the time in presence of others or alone;
- Violent behaviour regarding oneself (banging head against the wall, self mutilation, biting own hand...).

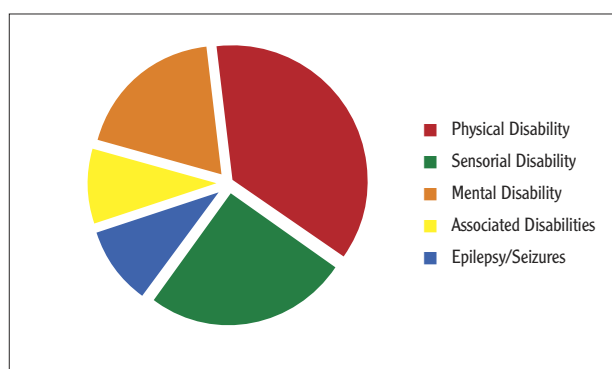
## Section D: Communication and Social Functioning Disorder (linked to no identified reason)

- Having repetitive, stereotyped body movements (rocking back and forth);
- Showing sudden and unpredictable physically violent behaviour towards other person (hitting, biting, scratching, spitting, pulling hair...);
- Showing sudden and unpredictable verbally violent behaviour towards other person (abusing, using foul language constantly...);
- Getting angry very easily, screaming/yelling without reason when touched.

## Section E: Epilepsy and Other Seizures<sup>13</sup>

- Fits/Seizures;
- Epilepsy signs;
- Fainting or passing out without reason.

Figure 5: The Overall Typology



The main type of disability reported in the NDSA was physical disability (36.5%), followed by sensorial forms (25.5%). It is important to note here that multiple physical or sensorial disabilities are included in these figures.

Mental disability and associated disability (more than one type of disability) account for similar proportions.

Epilepsy and seizures seem to affect almost one person with disability out of five. However these estimates are in line with the proportion found in other countries, which is roughly of 1% of the overall population.

Looking more closely at the physical disability category shows that over 46% physically disabled people have multiple physical disability, followed by 29.0% of paralysed and 12.0% each for physical deformity and lacking a limb.

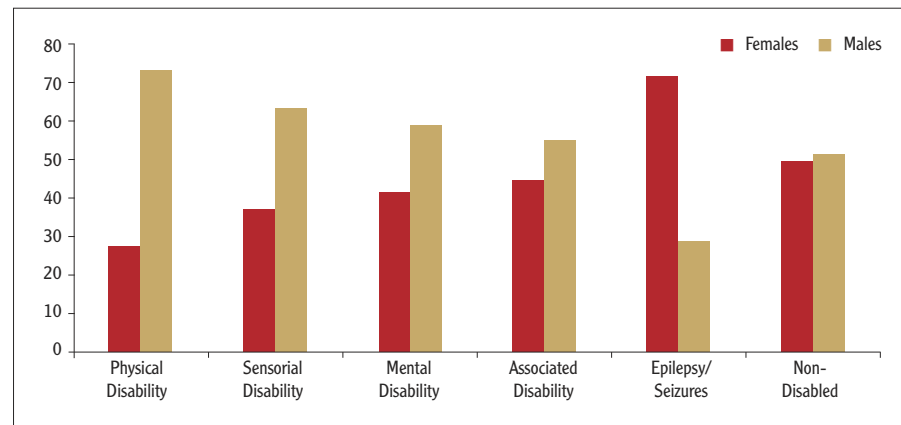
The sensorial disabled are divided between visual impaired (32.4%), hearing impaired (25.2%) and speech impaired (23.0%). Another 15.4% report hearing and speech disability together.

<sup>13</sup> For this section we proceeded with care. On the suggestion of an expert from Health Net International, Dr. Peter Ventevogel, we were careful with regard to “‘pseudo-epilepsy’ (women who have attacks that somehow resemble epilepsy and are often also called ‘mergi’ but are conversions or, to use an abandoned word, hysterical attacks). This can be quite prevalent in rural areas.” As a result we focused upon how these attacks impede and affect everyday functioning. We also were attentive to the duration of these attacks and the social settings of their occurrence. Lastly we were cautious regarding the interpretation of results found in this category.

Mental disability shows a much more complex structure. However, the two forms that do appear clearly in high proportions are psychological disability and learning disability.

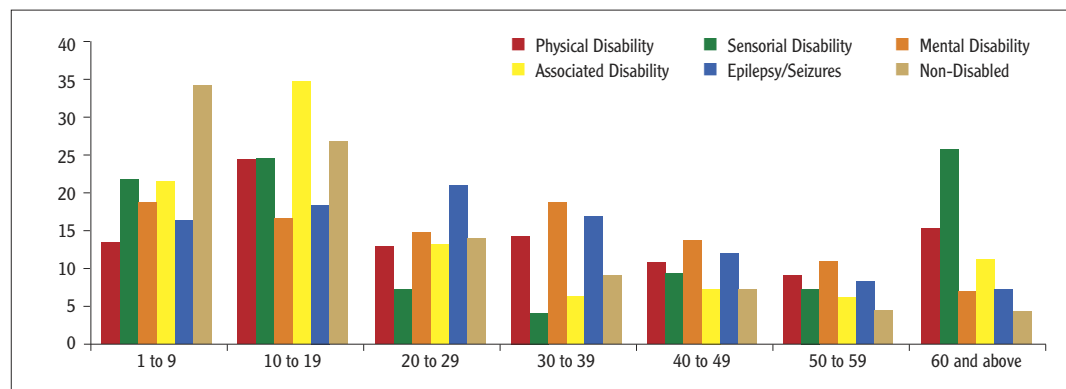
These findings are based on the 2.7% of the population detected through the screening questionnaire and who have serious difficulties in everyday functioning. The underestimation of mental forms of disability is a problem encountered in a number of surveys in the field.

**Figure 6: Sex-Ratio by Types of Disability**



The typology according to gender shows that whereas the majority of males with disability fall into the physical and sensorial categories, the highest proportion of females have seizures or epileptic fits that are disabling. For mental and associated disability there are also significant differences between the two sexes. It is only for epilepsy/seizures that the proportion of females is significantly higher than that of males.

**Figure 7: Typology According to Age**



At various ages, physical disability is very much present, considering that a majority of associated disabilities include physical forms.

Sensorial disability is highly prevalent among children and youngsters. This is also true for persons over the age of 60.

There is a high proportion of associated disability (more than one type) among people aged 10 to 19.

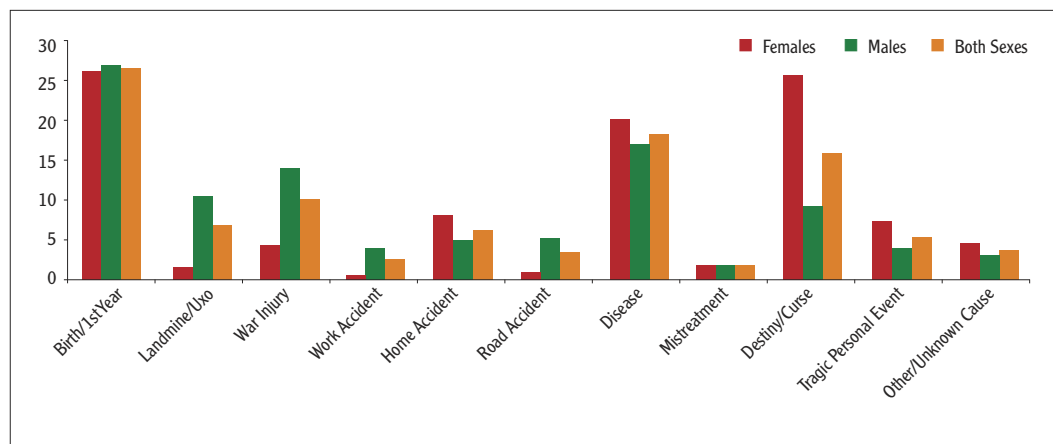
As for adults between 20 and 29, the level of physical disability and associated disability is almost equivalent, while the level of epilepsy and seizures is the highest.

Sensorial disabilities are prevalent at the earlier stages of life (before age 9) and then appear again with increasing age (especially after 60). This is closely linked to the main causes of sensorial disability, at birth or through accident in early stages, or loss of faculties due to age.

Mental disability seems to be present throughout, with the highest proportion between ages of 30 and 50.

In this section we asked the interviewees what causes they identified to explain their disability. The answers are reported here.

**Figure 8: Causes of Disability Identified by Respondents**



**Disability from birth, or acquired during the first year of life, represents 26.4 % of the total identified causes<sup>14</sup>.** This has been reported as the major explanation for disability. Disease or illness is the most common identified cause. However, we do believe that a large proportion of the first category could also come under this explanation. It is believed that improvement of health systems, particularly with the implementation of the Basic Package of Health Services (BPHS) including specific services for persons with disability, will contribute to better treatment and care, especially prenatal and birth care.

War-related disabled also constitute a considerable proportion: almost 17% of all declared causes are linked to past conflicts: landmines or UXO (6.8%) or other types of war injuries (10.0%): bullet, grenade, bomb, booby trap, etc. If one considers an average population of 25 million inhabitants in Afghanistan, this represents 123,000 people who were affected by war and its consequences; of these almost 50,000 are landmine or UXO survivors.

*War-related disabled also constitute a considerable proportion: almost 17% of all declared causes are linked to past conflicts*

Finally, a significant number of respondents gave supernatural explanations for their disability. Analyses show that these reasons are mainly given for mental forms of disability and epilepsy/seizures.

## Conclusions & Recommendations

### To Sum Up:

According to this first overview, Afghans with disability are most likely to:

- Live in Western and Central areas;
- Be men;
- Be physically disabled;
- Have been either disabled at birth/during the first year or have a war-related disability.

<sup>14</sup>We decided to combine « at birth » and « during the first year » in order to avoid stigma that is linked to disability caused from congenital factors. Our pre-tests showed that no one admitted that the disability was present « at birth ». In order to obtain responses we decided to widen the option. As a result this category can refer to congenital problems or difficult delivery, or to illness or disease during very early childhood.

*The effective prevalence rate of severe disability based on the screening tool is situated in the lower estimates that were considered for Afghanistan by experts. This rate is close to the previous estimates made by different surveys*

## Steps Forward:

### **Allow Future Comparisons with Other Surveys and with Other Countries in the Region**

Establishing a few benchmarks to define disability within the Afghan context seems to be essential in order to adequately monitor progress made in the future as well as assess how the country is doing with regard to neighbouring states in the region. A first step was taken in this direction during the UNESCAP 4th Workshop for Improving Disability Statistics and Measurement, held in Bangkok in June 2006. The main aim of this initiative was to introduce the principles and requirements for collecting, producing, and disseminating disability statistics at the national and international levels. A first step in this direction would be delineating the elements that define disability in Afghanistan, in line with regional standards<sup>15</sup>. This would allow reliable monitoring and inter-country comparisons.

### **Improving Knowledge about Afghans with Disability**

The effective prevalence rate of severe disability based on the screening tool is situated in the lower estimates that were considered for Afghanistan by experts. This rate is close to the previous estimates made by different surveys. In a country where life expectancy at birth is amongst the lowest in the world, this may signify that a proportion of Afghans with disability are more prone to disease, illness, accident or even neglect. These figures also suggest a lack of knowledge and awareness regarding shunned or hidden forms of disability where stigma and discrimination make detection difficult. On the other hand, if the threshold to define disability is based on the health set of 46 questions, then very severe disability rates 2.2% and severe disability rates 10.8% of the whole Afghan population.

The next step is to understand the living conditions of persons with disability, by looking more closely at the proportion of those who benefit from health services, education, employment, income and decent living conditions. The following sections will summarise this information according to various fields: try to bring into light what exists and what remains to be done.

<sup>15</sup> For more information please visit the website: <http://www.unescap.org/stat/meet/widism4/index.asp>

# The Health Picture

## Access, Costs, Needs

Since the end of 2001, attempts have been made by the government to secure peace and stability, and to rehabilitate the devastated infrastructures. Despite these efforts, the national health indicators remain alarming. The maternal mortality rate is reported to be 1600 per 100,000 live births, the under-five mortality rate is estimated at 172 per 1000 births and the infant mortality rate is 115 per 1000 births<sup>16</sup>. These statistics are the reflection of over twenty years of on-going conflict as well as political instability.

While general statistics are used to gauge the progress of the health sector in addressing the needs of the population, very little is known regarding the health status of one of the most vulnerable groups of Afghans, i.e., persons with disability. Knowledge regarding the health indicators of this population is very limited, even more so when it comes to their access to and use of health services. The 2005 National Disability Survey in Afghanistan is the first survey aiming to provide insight into the health status and challenges faced by Afghans with disability.

The Ministry of Public Health (MoPH) has been assigned the task of addressing the health needs of the Afghan population. In 2003, this ministry established a health services delivery policy called the Basic Package of Health Services (BPHS) which outlined seven areas of priority in: maternal and newborn health, child health and immunisation, public nutrition, communicable diseases (tuberculosis and malaria), mental health, disabilities, and finally, the supply of essential drugs. They were grouped into three tiers according to priority. Due to lack of knowledge on the scope of the problems, lack of resources and insufficient capacity to integrate services, both mental health and disabilities were associated with secondary tier interventions. With the revision of the BPHS in 2004 and 2005, the provision of mental health and rehabilitative services for disabled Afghans was elevated to first-tier interventions. Despite this, comprehensive development of service-provision activities has been slow and is in need of guidance.

### Types of Difficulty

In general, persons with severe disability reported a number of difficulties in their ability:

- To satisfy their daily self-care needs without any assistance or equipment (questions asked to children above 8 years of age and adults);
- To perform household chores (questions not asked to adult men);
- To carry out tasks outside the house/in the field.

This series of three major fields of activities gives a good overview of difficulties faced in everyday life by severely disabled persons. Looking at the ability to function in everyday life also helps understand what the impact of disability might mean to a household as a unit. The fact that a person with disability may require assistance in a variety of tasks implies the need for caretakers within the household and/or the community. A large number of people rely on the other members of their family to fulfil their basic daily needs.

### Daily Self-Care Needs

Our results show that a majority of persons with disability need some kind of assistance in everyday functioning. This proportion can range from a minimum of 12.9% for going to the toilet and 13.4% for getting dressed,

*While general statistics are used to gauge the progress of the health sector in addressing the needs of the population, very little is known regarding the health status of one of the most vulnerable groups of Afghans, i.e., persons with disability*

<sup>16</sup> UNDP (2004) op. cit.

to a maximum of 37.4% unable to cook a meal for themselves. Hence, if 4.1% reported being unable to eat or drink without help, 10% are able to do it with difficulty.

If we consider both the inability and the difficulty to accomplish such routines, it is between one third and half of the persons with disability who are confronted with difficulties at various levels in their daily tasks:

- 48.6% have difficulties bathing and ablution;
- 47.2% have difficulties moving around inside the house;
- 37.8% have difficulties getting dressed;
- 38.5% have difficulties going to the toilet;
- 14.1% have difficulties drinking and eating by themselves.

**Table 2: Proportion of People with Disability Able to Carry Out Daily Self-Care Tasks by Main Types of Disability**

Data presented below excludes respondents under the age of 8.

Daily Self Care Routines	Type of Disability	Yes (%)	Yes with Difficulty (%)	No (%)
Bathing or Ablution	Physical Disability	32.6	54.5	12.9
	Sensorial Disability	64.0	20.1	15.9
	Mental Disability	54.3	18.5	27.2
	Epilepsy/Seizures	92.3	5.3	2.4
	Associated Disabilities	32.1	28.2	39.3
	All Together	51.4	29.9	18.7
Getting Dressed	Physical Disability	48.2	43.8	7.9
	Sensorial Disability	72.0	18.7	9.3
	Mental Disability	65.4	13.6	21.0
	Epilepsy/Seizures	95.9	3.0	1.2
	Associated Disabilities	40.5	23.8	35.7
	All Together	62.2	24.4	13.4
Preparing Meals for Yourself	Physical Disability	33.7	31.1	35.2
	Sensorial Disability	50.0	8.9	41.1
	Mental Disability	49.4	4.9	45.7
	Epilepsy/Seizures	85.2	3.6	11.2
	Associated Disabilities	28.6	16.7	54.8
	All Together	46.7	15.9	37.4
Going to the Toilet	Physical Disability	42.8	45.5	11.7
	Sensorial Disability	65.4	21.0	13.5
	Mental Disability	84.0	6.2	9.9
	Epilepsy/Seizures	96.4	3.0	0.6
	Associated Disabilities	41.7	29.8	28.6
	All Together	61.5	25.6	12.9
Eating/Drinking	Physical Disability	81.2	15.5	3.2
	Sensorial Disability	90.7	6.1	3.3
	Mental Disability	95.1	1.2	3.7
	Epilepsy/Seizures	97.0	2.4	0.6
	Associated Disabilities	67.7	21.4	11.9
	All Together	85.9	10.0	4.1
Moving Around	Physical Disability	23.2	55.9	20.9
	Sensorial Disability	61.7	22.0	16.4
	Mental Disability	82.7	9.9	7.4
	Epilepsy/Seizures	92.3	6.5	1.2
	Associated Disabilities	41.7	35.7	22.6
	All Together	52.8	31.6	15.5



If we look more closely at the various types of disability, as expected, it is the persons having associated disabilities who report the most difficulty in performing daily personal tasks such as:

- Bathing or ablution: 67.5% are not able or have some difficulty;
- Getting dressed: 59.5%;
- Preparing meals: 71.5%;
- Going to the toilet: 58.4%;
- Eating and drinking: 33.3%;
- Moving around: 58.3%.

In fact, persons with associated disabilities have the lowest rates of ability to perform daily self-care tasks, ranging from only 28.5% persons being able to prepare meals for themselves to 66.7% being able to eat and drink without difficulty.

People with physical disability have a high level of inability and difficulty in accomplishing daily personal routines on their own without any equipment. The exception is drinking and eating: only 3.2% of physically disabled persons are unable to perform this task. Difficulties in performing tasks that require more movement were logically higher.

People with mental disability, including learning, psychological, intellectual and social disabilities, have difficulties with all activities requiring the use of intellectual faculties. Bathing (45.7% with both mild and severe difficulties), preparing meals (50.6%) and getting dressed (34.6%) were recognised as the most difficult tasks to perform.

People with epilepsy and other types of seizures have the least difficulty in performing their daily tasks. This is probably due to the fact that except during the periods of seizure, they are able to do their daily tasks with no difficulty.

## Household Chores

The daily household's duties include sweeping, cooking meals, washing dishes, looking after young children, looking after elder members and doing laundry. These tasks are mainly the domain of women and children in the Afghan society. This cultural specificity explains why the questions related to household tasks were not asked to males<sup>17</sup>. Therefore, the results presented exclude men above the age of 14 and children under the age of 8. However, for women, the ability to carry out these tasks is of the utmost importance. This impacts the contribution to family life, and more generally, influences social acceptance.

Whatever the activity considered, more than 70% of non-disabled people are able to perform any of these tasks, whereas persons with disability able to perform them are always less than 50%. This is to be compared to the results presented in the previous section in which persons with disability are a majority able to take care of themselves. The most demanding tasks within the household are doing the laundry and looking after elder members.

The ability to perform a given task within the house depends on the type of disability that a person has. Persons with physical and associated disabilities have the most difficulty, followed by persons with sensorial disabilities. Then come those with mental disability; whereas persons with epilepsy or other forms of seizures have the least difficulty in performing these tasks. With the exception of this last case, the difficulties in carrying out household tasks are considerable. Here again, these results show the impact of impairment on the ability to perform daily household tasks for persons with disability, whatever the type of disability.

*Whatever the activity considered, more than 70% of non-disabled people are able to perform any of these tasks, whereas persons with disability able to perform them are always less than 50%. The most demanding tasks within the household are doing the laundry and looking after elder members*

<sup>17</sup> During the pre-test of the questionnaire, the men interviewed answered that they were not able to do the household chores, confusing the ability to do these and social practices.

**Table 3. Proportion of Persons with Disability Able to Perform Household Routines by Main Types of Disability**

(Data presented below excludes respondents under the age of 8 and men above age 14)

Household Tasks	Type of Disability	Yes (%)	Yes with Difficulty (%)	No (%)
Sweeping Around	Physical Disability	17.8	28.3	53.9
	Sensorial Disability	46.3	4.5	49.3
	Mental Disability	52.2	4.3	43.5
	Epilepsy/Seizures	76.0	9.3	14.7
	Associated Disabilities	14.1	12.5	73.4
	All Together	43.2	13.4	43.4
Cooking Meals for Everyone	Physical Disability	13.8	19.1	67.1
	Sensorial Disability	34.3	4.5	61.2
	Mental Disability	28.3	8.7	63.0
	Epilepsy/Seizures	66.7	5.3	28.0
	Associated Disabilities	10.9	9.4	79.7
	All Together	34.2	9.7	56.0
Washing Dishes	Physical Disability	20.4	23.0	56.6
	Sensorial Disability	40.3	7.5	52.2
	Mental Disability	43.5	15.2	41.3
	Epilepsy/Seizures	76.0	6.7	17.3
	Associated Disabilities	17.2	10.9	71.9
	All Together	42.1	12.6	45.2
Looking after Young Children	Physical Disability	30.9	23.0	46.1
	Sensorial Disability	45.5	6.0	48.5
	Mental Disability	34.8	10.9	54.3
	Epilepsy/Seizures	76.7	5.3	18.0
	Associated Disabilities	21.9	4.7	73.4
	All Together	46.3	10.8	42.9
Looking after Elder Members	Physical Disability	24.3	16.4	59.2
	Sensorial Disability	34.6	6.0	59.4
	Mental Disability	30.4	8.7	60.9
	Epilepsy/Seizures	72.0	3.3	24.7
	Associated Disabilities	17.2	6.3	76.6
	All Together	39.6	8.4	51.9
Doing the Laundry	Physical Disability	22.1	15.7	62.3
	Sensorial Disability	31.3	8.2	60.4
	Mental Disability	39.1	4.3	56.5
	Epilepsy/Seizures	66.4	7.4	26.2
	Associated Disabilities	10.9	9.4	79.7
	All Together	33.2	10.8	56.0

**Over 75% persons with associated disabilities** have difficulty in all of the items mentioned (85.9% have difficulty sweeping the house, 89.1% have difficulty cooking a meal, 82.8% have difficulty washing the dishes, 78.1% have difficulty looking after young children, 82.9% have difficulty looking after elder members, 89.1% have difficulty doing the laundry).

As expected, **persons with physical disability** have considerable difficulty in carrying out tasks that are physically demanding, such as sweeping (82.2%), preparing meals (86.2%), washing dishes (79.6%), looking after children (69.1%), looking after elder members (78.1%) and doing the laundry (77.9%).

A high proportion of **persons with sensorial disability** report not being able to carry out these tasks easily: 53.8% have difficulties in sweeping, 65.7% in cooking meals, 59.7% in washing dishes and 68.6% in doing the laundry. These figures could also signify that these persons are not expected to do these tasks, as there is a problem of communication. For looking after children and elders 54.5% and 65.4% respectively of persons with sensorial impairments have difficulties. These results are more in line with expectations as the tasks do entail interaction with others.

**Persons with mental disability** also show a high proportion who have difficulties carrying out housework. For some tasks the proportion of persons having great difficulty is less than in previous categories: 47.4% claim to have problems in sweeping and 60.8% find it challenging to do the laundry. However, 66.5% have difficulty washing dishes, 65.2% have difficulty in looking after children and 60.8% have the same regarding elders.

Lastly, it is noticeable that the responses to this question are less nuanced between “yes, with difficulty” and are more often a categorical “no”, with the exception of persons with physical disability. In the latter category, the “yes with difficulty” is far more frequent an answer. This suggests a strong belief that the person has regarding the ability to do certain things.

### Chores Outside the House/in the Field

This third set of tasks is related to the ability to move outside the household and the compound. Few non-disabled persons report inability to perform these tasks. In these cases, the explanation lies in the fact that the women are not allowed to perform farming activities, especially in Pashto areas<sup>18</sup>.

Persons with disability reported having the most difficulty with performing manual labour, (working in the field) or riding a bicycle or an animal. There is a clear distinction between the ability to perform these two tasks and being able to perform the other ones mentioned in Table 4. More than 60% of the respondents having disability reported not being able at all to work in the field or ride a bicycle or an animal, whereas only 26.7% are not able to climb stairs, 31.1% cannot go the bazaar and 48.0% are unable to carry heavy things. If the persons with disability having difficulty to work in the field or ride a bicycle are considered together, then only one fourth are able to accomplish these tasks outside the house.

People with physical disability and associated disabilities are the most challenged when it comes to tasks that require high mobility and physical strength. The proportion of those experiencing difficulty is again very high:

- At the lower proportion, this means that 76.4% persons with physical disability and 61.5% with associated disabilities respectively have difficulty in some way with doing the shopping and climbing stairs.
- At the higher proportion, this implies that 93.2% of those with physical disability and 90.0% with associated disabilities have difficulty working in the field.

*Persons with disability reported having the most difficulty with performing manual labour, (working in the field) or riding a bicycle or an animal*

<sup>18</sup> See ALDEN W. L. (2004), “Looking for Peace in the Pastures: Rural Land Relations in Afghanistan”, *Afghanistan Research and Evaluation Unit Report*, AREU, December 2004, 125 pp.

**Table 4: Proportion of Persons with Disability Able to Carry out Tasks Outside the House by Main Types of Disabilities**

(Data presented below excludes respondents under the age of 8)

Tasks Outside the House or Compound	Type of Disability	Yes (%)	Yes with Difficulty (%)	No (%)
Climb Stairs	Physical Disability	19.0	42.0	38.9
	Sensorial Disability	56.1	15.7	28.3
	Mental Disability	76.7	10.5	12.8
	Epilepsy/Seizures	80.9	16.3	2.8
	Associated Disabilities	35.6	27.8	36.7
	All Together	46.9	26.5	26.7
Go to the Bazaar/ Shop on Your Own	Physical Disability	23.6	46.3	30.1
	Sensorial Disability	46.9	17.9	35.3
	Mental Disability	54.0	10.3	35.6
	Epilepsy/Seizures	74.2	9.6	16.3
	Associated Disabilities	32.2	17.8	50.0
	All Together	42.6	26.3	31.1
Carry Heavy Things	Physical Disability	6.8	27.0	66.2
	Sensorial Disability	48.2	8.9	42.9
	Mental Disability	55.2	10.3	34.5
	Epilepsy/Seizures	74.7	9.0	16.3
	Associated Disabilities	17.8	15.6	66.7
	All Together	35.4	16.6	48.0
Work in the Field	Physical Disability	6.8	22.2	71.0
	Sensorial Disability	34.4	6.7	58.9
	Mental Disability	28.7	9.2	62.1
	Epilepsy/Seizures	49.4	6.7	43.8
	Associated Disabilities	10.0	6.7	83.3
	All Together	24.0	12.7	63.3
Ride a Bicycle or an Animal	Physical Disability	16.2	16.8	67.0
	Sensorial Disability	29.9	7.6	62.5
	Mental Disability	29.9	2.3	67.8
	Epilepsy/Seizures	50.0	5.6	44.4
	Associated disabilities	13.3	5.6	81.1
	All Together	27.0	10.0	63.0

- The persons who are paralysed or have multiple physical disabilities face difficulty in all the tasks. The proportion is consistently above 85% for those paralysed, and 70% for persons with associated disabilities. The percentages are even higher for carrying heavy things, working in the field or riding bicycle or animals.

Regarding persons with sensorial disabilities, findings show that:

- Those having visual impairment have greater difficulty with all tasks over those with other sensorial impairment.

- For all persons with sensorial impairments the greatest difficulties encountered are for working in the field and riding a bicycle or an animal. This is partly due to the fact that women are not allowed to work outside the house in remote rural areas.

In contrast to the above, people having mental and intellectual disability, as well as the cases of epilepsy and other forms of seizures, are more able to perform duties outside the house, with the exception of working in the field and riding animals or bicycles. Less than 30% people with mental or intellectual impairment and 50.0% persons affected by epilepsy/seizures are able to perform these tasks. Here again, it is highly likely that the fact that a majority of persons in this category are females also has an impact; gender norms determine which tasks are not to be carried out by women outside the house.

## Mental Health of Afghans with Disability

It is believed that a large number of Afghans indicate having high levels of mental distress, which could mean anxiety, depression, trauma, stress, etc. A few studies have looked at this issue in particular for the overall population<sup>19</sup>. Our objective in this section is to present an overview of what the mental health indicators look like. However, in order to present a coherent picture of mental health of Afghans with disability we chose to ask questions focusing on a few categories that came up as being important after discussion with other partners, as well as pre-tests. There is, inevitably, an overlap between some forms of disability identified by the screening, and certain queries of the health questionnaire.

The following section reports the responses of persons with disabilities to questions dealing with mental distress. For clarity we have divided this analysis into 3 major fields:

- Behavioural problems which consist of 2 main domains: isolation/withdrawal and violence;
- Problems related to communication and interaction with others;
- Depression and anxiety signs.

Before presenting the findings, it is important to stress that all the questions regarding some psychological or social difficulty emphasised the lack of identifiable reason for the problem. This was important in order to differentiate a temporary problem, linked to a specific event or incident, as opposed to a recurrent or chronic problem.

## Non-Disabled and Persons with Disability

The first affirmation that can be made is that the proportion of persons with disability showing signs of mental distress is much higher than the proportion of non-disabled showing the same signs in the recent past.

Figure 9 clearly shows that the difference between persons with disability and non-disabled persons is considerable with regard to mental distress indicators. The items where the proportion of non-disabled is highest are the ones linked to anxiety and depressive signs. An analysis by type of difficulty provides a better understanding of the situation.

## Behavioural Problems: Isolation, Sadness, Fear and Violence

This part reports the responses of persons who suffer from behavioural problems such as isolation and withdrawal from others, violent reaction to outside solicitations and pressure, difficulty in communicating, and anxiety or depression. All these items are examined below.

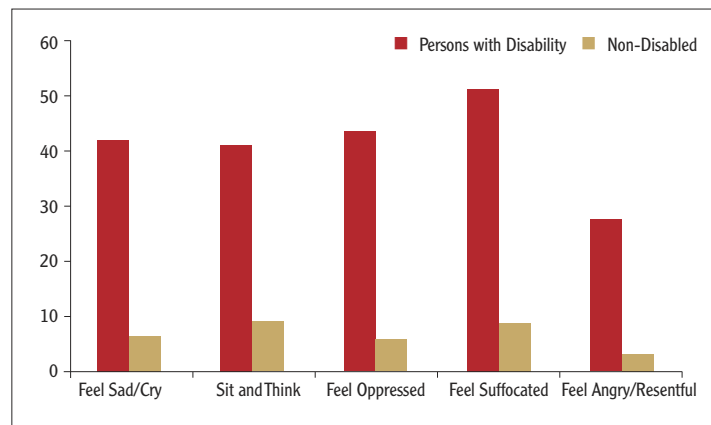
<sup>19</sup> RASEKH Z., BAUER H.M., MANOS M.M., IACOPINO V. (1998) "Women Health and Human Rights in Afghanistan", *Journal of American Medical Association*, 1998, no. 280, pp. 449-55.

CARDOZO B.L., BILUKHA O.O., CRAWFORD C.A., SHAIKH I., WOLFE M.I., GERBER M.L., ANDERSON M. (2004), "Mental Health, Social Functioning, and Disability in Post-War Afghanistan", *Journal of American Medical Association*, August 4, 2004; no. 292, pp. 575 - 84.

SCHOLTE W.F. OLFF M., VENTVOGEL P., VRIES (de) G. J., JANSVELD E., CARDOSO B.L., GOTWAY CRAWFORD C.A. (2004). "Mental Health Symptoms Following War and Repression in Eastern Afghanistan", *Journal of American Medical Association*, no. 292, pp. 585-93.

**Figure 9. Distribution of Persons with Disability and Non-Disabled Showing Anxiety and Depression Signs**

(These questions were only asked to persons over age 14)



*Behavioural problems related to isolation are described by a series of items characterising specific attitudes, linked to social interaction and acceptability within the community in general*

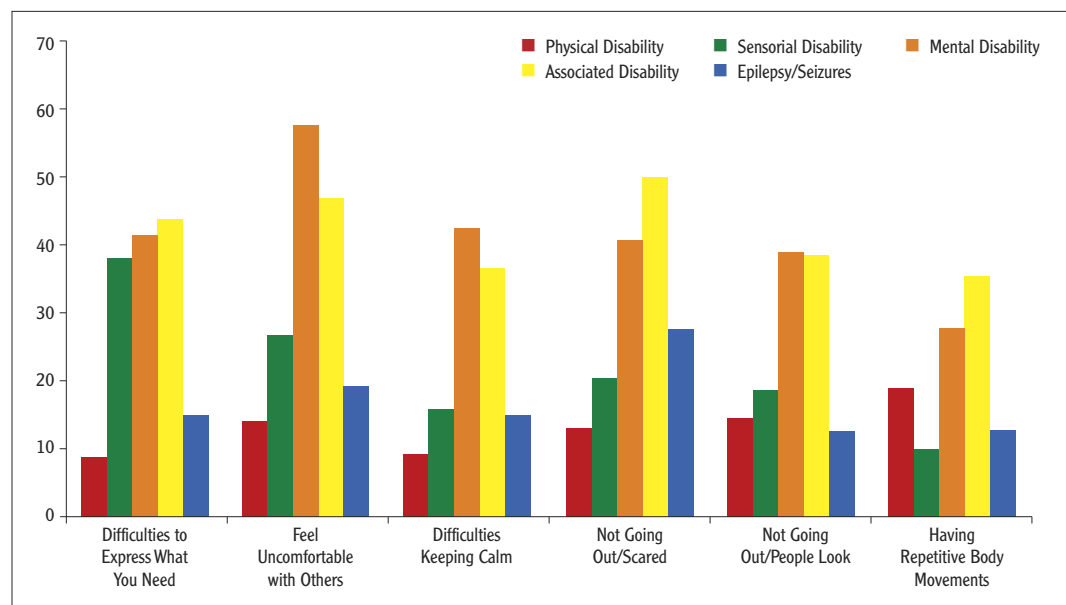
### Withdrawal from the Rest of the World

Behavioural problems related to isolation are described by a series of items characterising specific attitudes such as: “difficulty expressing one’s needs”, “feeling uncomfortable with other people”, “difficulty keeping calm”, “feeling scared when going out of the house for no particular reason”, “not going out of the house, feeling looked at by people” and “having repetitive, uncontrolled body movements”. These aspects are closely linked to social interaction and acceptability within the community in general.

Figure 10 shows that persons with mental and associated disability are the ones who have the most difficulty when it comes to expressing needs and moving around within the community. Persons with physical disability have the least difficulty in this field.

For sensorial disability, the picture is different according to the types of impairment. As expected, people with speech impairment are the ones unable to express their needs to others (84.1%) while the average proportion is 23.5% for all types of disability. People with hearing impairment are the highest proportion among all disabled faced with behavioural difficulties. Hearing-impaired people are also “not comfortable with other people” and are the highest proportion to report problems regarding expression of needs.

**Figure 10: Distribution of People Reporting Difficulties Related to Social Behaviour According to Main Types of Disabilities**

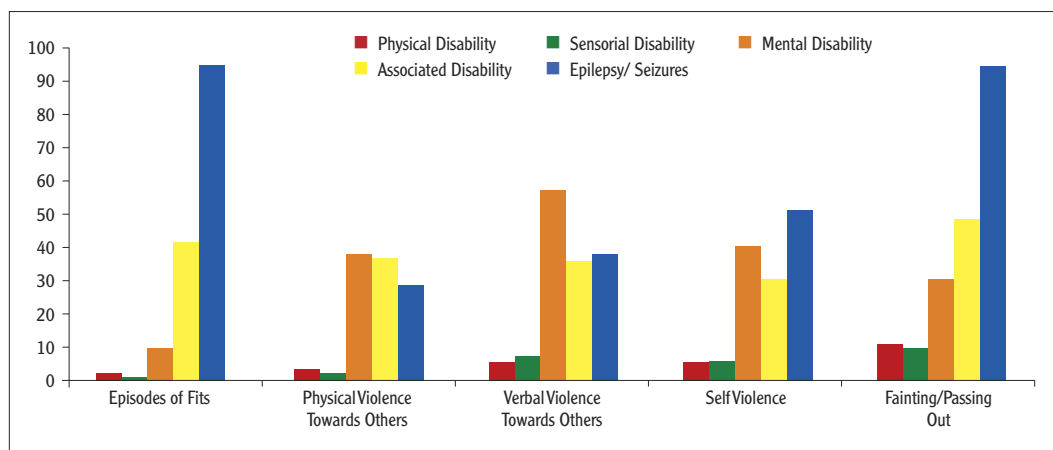


These dimensions contribute to the overall well being of the person. It is obvious that persons with physical disability do seem to be more easily accepted, as they can express their needs more easily. For other categories, it is challenging to do this; as a result they may remain isolated.

### Reacting Violently to Outside Surroundings

The violent attitudes that may take place in reaction to outside pressure are described by five specific items such as: fits, physically violent behaviour towards others, verbally violent behaviour towards others, violent behaviour towards oneself, fainting or passing out. These types of behaviour are closely related to the previous section. They are often a result of frustration linked to the fact of not being able to get the message through: not being able to make oneself understood.

**Figure 11: Distribution of Persons with Disability Having Violent Reactions According to Main Types of Disability**



It is clear that persons with physical and sensorial disability have far less violent reactions towards others or towards themselves. It is the persons who have associated disability, who report a high proportion of individual episodes such as fits and fainting as well as violence towards oneself. On dimensions of violence towards others, in addition to the associated disabilities there are persons with mental forms of disability. As expected, persons with epilepsy and other seizures report having experienced episodes of fits and fainting over the last six months.

### Communication Difficulties

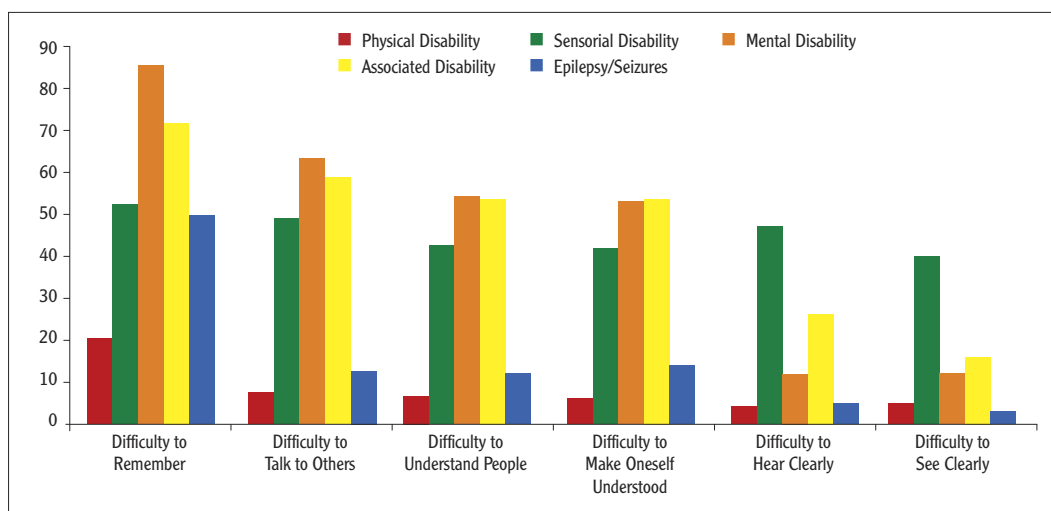
In order to assess the difficulty to communicate, six abilities are considered: “remember things”, “talk to others”, “understand what people say”, “make oneself understood”, “hearing clearly”, and “seeing clearly”.

Persons with sensorial, mental or associated disabilities are a significantly higher proportion to report problems regarding communication when compared to persons with physical disabilities. It is noticeable that persons with mental forms of impairment (including associated disabilities) are a considerably higher proportion having difficulties related to memory. A majority of them have trouble talking to others. Persons with sensorial impairments having problems related to memory are probably older people, challenged with short term memory loss.

To summarise, when comparing the responses by categories of disability, it appears that the persons with mental disabilities and those with associated disabilities have the greatest difficulty, especially with regard to memory: 85.2% persons with mental disabilities and 74.1% persons with associated disabilities have memory difficulties. Similarly, persons with epilepsy/seizures report the least difficulty, with the exception, once more, of memory.

*Persons with sensorial, mental or associated disabilities are a significantly higher proportion to report problems regarding communication and difficulties related to memory when compared to persons with physical disabilities*

**Figure 12: Distribution of Persons with Disability Having Communication Difficulties According to Main Types of Disability**



### Depression and Anxiety Signs

After more than two decades of conflict, anxiety and depression related disorders are widespread throughout the country's population. Nevertheless, the corresponding symptoms appear to be much more frequent among the persons with disabilities. Ten items can be used to characterise these disorders: "want to stay locked up inside the house", "feel very sad or cry without reason", "do not feel hungry for long period of time", "feel afraid for no reason", "sit for a long time thinking", "want to live somewhere else", "have rapid changes of mood", "feel oppressed for no reason", "feel suffocated for no reason", "feel angry and resentful for no reason". In order to look at the signs, the surveyors were trained to emphasise "for no reason" after each item.

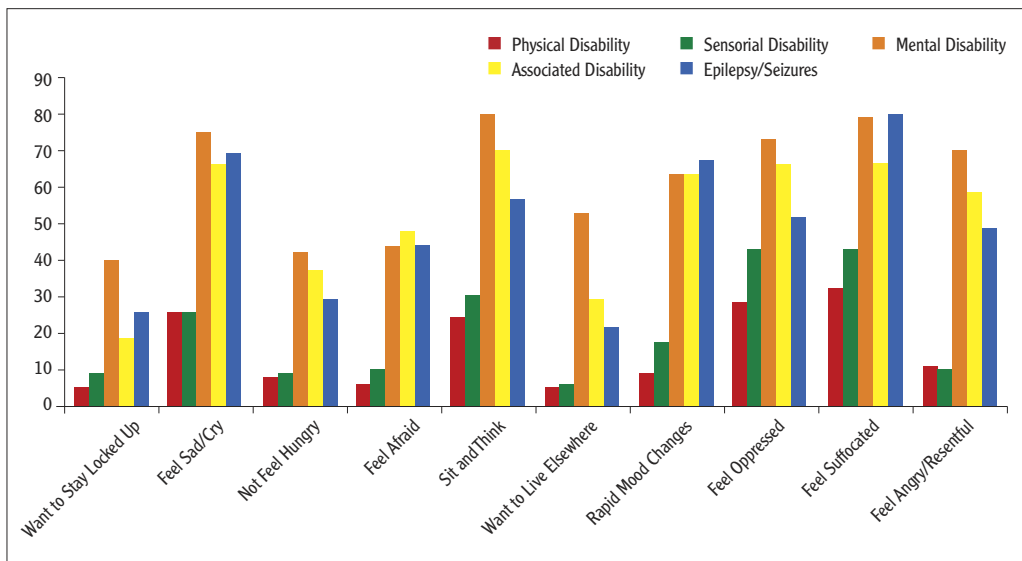
For each item, persons with sensorial or physical disabilities seem to show less signs of depression and anxiety. Yet, a significant proportion has the following signs of depression: "feeling sad/ crying without reason" (proportion of persons with sensorial and physical disability 25.0%), "sitting for a long time and thinking" (24.2% and 30.3% for the same), "feeling oppressed without reason" (28.1% and 42.8%), and "feeling suffocated without reason" (32.3% and 42.8% respectively). The existence of anxiety and depression signs is common in the population of physically disabled and even more among the sensorial category. This suggests that not only the trauma of impairment and of its causes (war, accident, disease...) is highly affecting the mental health of these people, but also that hopelessness and frustration are probably taking their toll on their mental health.

The situation is extremely worrying for persons with mental disability, epilepsy and associated disability. Out of the ten symptoms, the proportion of persons with mental disability that have experienced them recently ranges above 40% for all of them, and above 70% for half of them: "feel sad/cry" (74.6%), "sit and think" (79.4%), "feeling oppressed" (72.6%), "feeling suffocated" (77.8%), "feeling angry and resentful" (69.8%). While family is the major value in the Afghan culture, more than half of the people with mental or intellectual disability would "like to live away from their family", followed distantly by the proportion of people with associated disability (29.1%) and people with epilepsy/seizures (21.5%). 6 out of 10 signs are present in more than half the proportion of people with epilepsy/seizures or with associated disability: respectively 68.9% and 65.5% by "feel sad/cry", 56.3% and 69.1% by "sit and think", 66.7% and 63.0% by "rapid changes of mood", 51.1% and 65.5% by "feeling oppressed", 79.3% and 65.5% by "feeling suffocated", 48.1% and 58.2% by "feeling angry and resentful". As for persons with epilepsy/seizures, these findings may indicate that a certain portion of these may also present some additional mental problems such as depression.

*The existence of anxiety and depression signs is common in the population of physically disabled and even more among the sensorial category*



**Figure 13: Distribution of Persons with Disability Above 14 Showing Depression or Anxiety Signs According to Main Types of Disability**



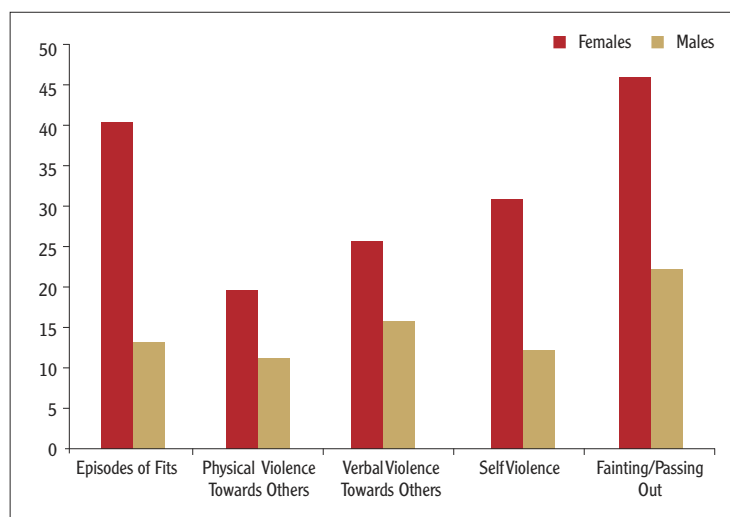
These results also suggest that persons with these disabilities are painfully aware of their situation. They may also believe that they are a burden on the family and rejected by the community. This is clearly a consequence of lack of social understanding and, as a result, of social acceptance of these forms of disability. A previous study<sup>20</sup> has shown that often causes for mental forms of disability are believed to be supernatural. There is an urgent need to build awareness and sensitize the close family members to these forms of disability.

*Persons with mental difficulties are painfully aware of their situation. They may also believe that they are a burden on the family and rejected by the community*

### Mental Health of Women with Disability

First, we can notice that the proportion of women reporting violent episodes is higher than that of men. This difference is even more obvious when we look at episodes regarding violence towards oneself.

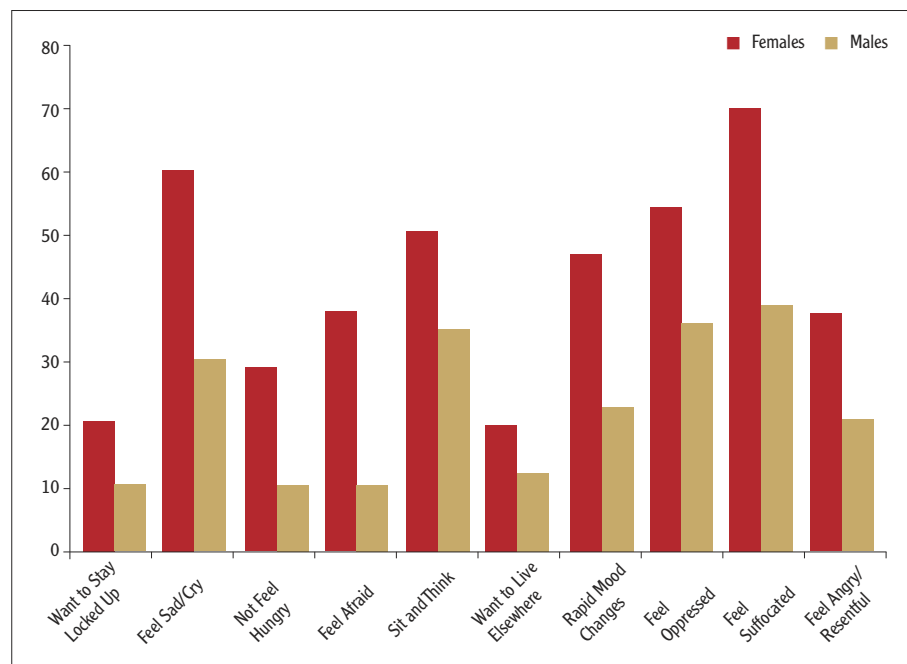
**Figure 14: Distribution of Persons with Disability Above 14 Showing Violent Episodes and by Gender**



<sup>20</sup>THAKKAR M., CERVEAU T., DAVIN E., (2004), "Afghan Perception on Disabilities, A Research Project on the Perceptions and practices Regarding Disability in Afghanistan, to Inform a Communication Strategy", Study carried out by ALTAI Consulting for UNICEF, UNOPS, UNDP, Kabul.

Comparing the situation between males and females concerning the symptoms of anxiety and depression, we find even sharper disparity than for violent behaviour. This is in line with the findings of other surveys<sup>21</sup>. While the highest proportion of men with disability is 38.9% for “feeling suffocated”, the proportion of the same is 70.1% for women with disability. Similarly, for four of the parameters, the proportion for men is about 30%, whereas for women these figures are above 50%: “feel sad/cry” (59.8% for women as compared to 30.2% for men), “sit and think” (50.4% compared to 34.9%), “feeling of oppression” (54.5% compared to 36%), “feeling of suffocation” (70.1% compared to 38.9%). These signs are particularly characteristic of depression and show the distressing mental health situation of women with disability in the country. These results are similar to those found by the CDC survey held in the Nangarhar province of Afghanistan in 2002, which show that all the trauma exposures were translated into significant scores for anxiety and depression<sup>22</sup>.

**Figure 15. Distribution of Persons with Disability above 14 Showing Depression or Anxiety Signs and by Gender**



*The status of women in Afghan society is changing. Due to a breakdown of family structures and migration to cities, the role of men as providers and protectors is no longer a given*

The higher proportion of women with depression and anxiety signs results from a combination of factors.

First of all, because of disability, their social status, valorised by the ability to get married and become a mother might be suddenly jeopardised by a disabling event, thus resulting in lowered self-esteem<sup>23</sup>.

The status of women in Afghan society is changing. Due to a breakdown of family structures and migration to cities, the role of men as providers and protectors is no longer a given. As a result, a number of women have to earn a living and step out of the houses in a context, which can be hostile and challenging.

Last but not least, they have also suffered the war and its consequences. Among displaced persons due to war, women and children represent three quarters of the massive exodus of millions of people<sup>24</sup>. They were also victims of violence, experiencing and witnessing loss and mistreatment as well as lack of security and basic commodities: all this can have resulted in psychological trauma and distress.

<sup>21</sup> RASEKH Z. et al. (1998), JAMA, op. cit.

<sup>22</sup> SCHOLTE W.F., et al. (2004) JAMA op. cit.

<sup>23</sup> MEEKOSHA H. (2004), “Gender and Disability”, *Encyclopedia of Disability*, Sage.

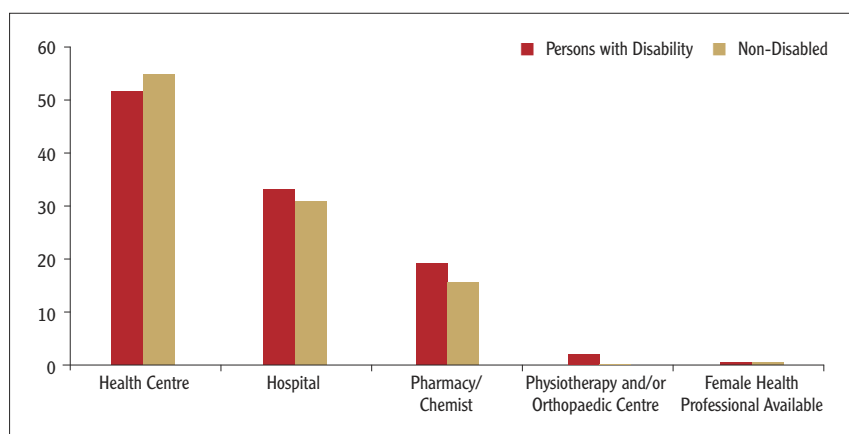
<sup>24</sup> BHUTTA Z. A. (2002), “Children of War: the real casualties of the Afghan Conflict”, *British Medical Journal*, 324: 350.

## Health Services

This section presents the findings with regard to the access and use of health services. Questions were asked regarding the access, expenditure and barriers faced within the existing facilities. Figure 16 reports the responses of persons with disability and the non-disabled according to the two main types of health services available. The results show that the persons with disability and non-disabled have similar responses:

- 51% persons with disability and 54.3% non-disabled report having a health centre available;
- 68.3% and 67.1% respectively report having a private clinic or doctor available;
- 32.4% and 30.5% respectively report having a hospital available.

**Figure 16. Types of Health Services Available According to Persons with and without Disability**



If we consider the frequency of use of services in the year preceding the survey, a high percentage of non-disabled persons (31.2%) have been to health facilities only once. The majority (52.5%) of persons with disability went to the health facility at least twice during the one year period considered. There are three main hypotheses explaining this result, the first being that persons with disabilities undergo ailments more frequently than the non-disabled, requiring that they go to a health facility for treatment more often. The second is that they hope to find some new treatment for their impairment. Thirdly, persons with disabilities return to the facilities multiple times due to the need to repeat treatment. Regardless of the reasons, persons with disabilities visit facilities more frequently than those without disability.

Lastly, the NDSA analysis shows that persons with mental disability and those having epilepsy/seizure problems use traditional cures (bone-setter, mullah, religious persons...) more often, hoping to find a cure for their problems. 26.1% persons with disability used traditional and religious cure in the past year. Of those who used a traditional or religious cure, 65.7% visited a mullah, while 25.7% went on a pilgrimage or did a special prayer.

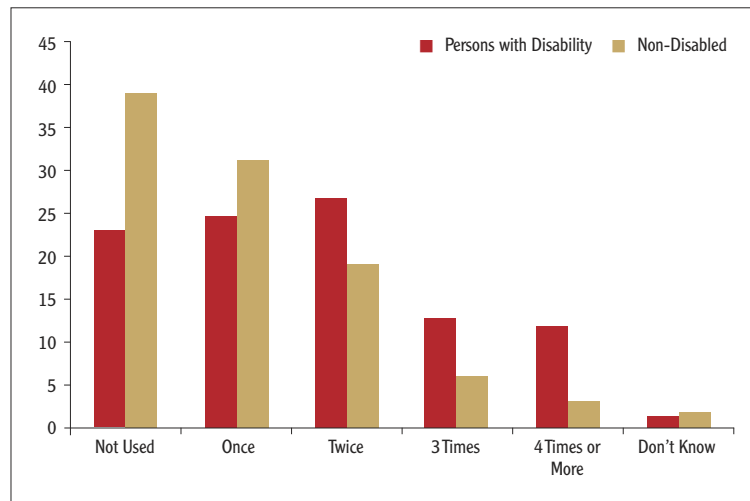
### Barriers to Accessing Health Care and Services

The health system is under reconstruction in Afghanistan. Considerable efforts have been made since 2002 to provide access to facilities in the entire territory. Nevertheless, many gaps remain, especially for treatment of disability: lack of trained medical staff is a major challenge for public planners. This section gives a quick overview of difficulties linked to health services. For a more in-depth analysis, one can refer to the survey carried out by the Ministry of Public Health and Johns Hopkins University Third Party Evaluation Team<sup>25</sup>.

*Persons with disabilities undergo ailments more frequently than the non-disabled, requiring that they go to a health facility for treatment more often*

<sup>25</sup> See MINISTRY OF PUBLIC HEALTH and JOHNS HOPKINS UNIVERSITY (2005), *Report on Health Seeking Behaviour, Health Expenditures, and Cost Sharing Practices in Afghanistan*, Kabul, 60 pp.

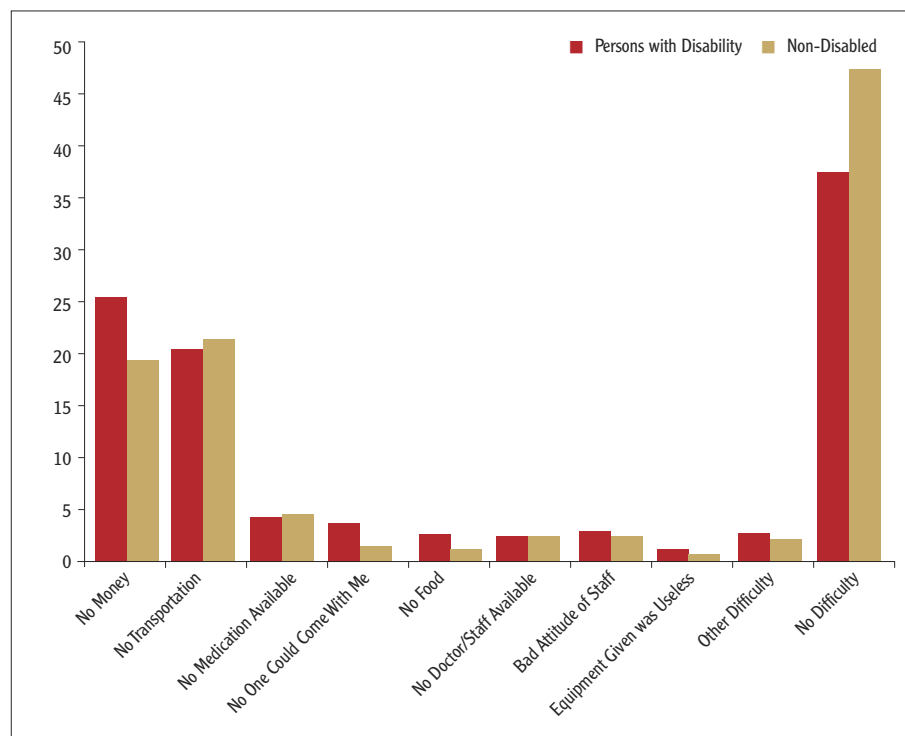
**Figure 17. Number of Visits to Health Services in One Year According to Persons with Disability and Non-Disabled**



When persons with disabilities were asked about barriers to health services, 37.2% professed no difficulty in accessing health care while 47.1% non-disabled persons reported having faced no difficulty. This is an expected result. Persons with disabilities probably require more complicated medical procedures that the often under-qualified medical staff can provide, especially in rural areas. Among difficulties reported, persons with disability faced problems mainly regarding money for fees or medication and transportation (25.1%), followed by the absence of transportation (20.0%), and far behind, the absence of medication (4.0%). Non-disabled people also face difficulty with transportation (21.1%), lack of money (19.0%) and absence of medication (4.2%).

Overall, we can state that the access being low, the main difficulties remain money and transportation. It can be expected that once access does improve, new problems will come up within the services if no measures are taken for training and sensitization of the staff.

**Figure 18. Distribution of the Difficulties Encountered During the Visits to Health Services**



Respondents could give up to 3 answers for each visit. "No difficulty" is counted once by visit.

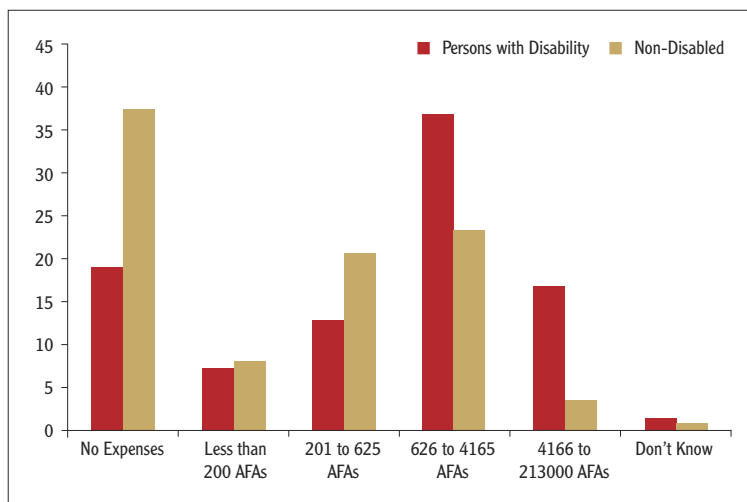
## Health Costs

Health expenses of persons with disability can be considerable and can weigh upon the finances of the household. Results in this field indicate that a larger percentage of non-disabled persons (39.7%) state that they do not have any expenses for health, compared to 20.1% persons with disabilities. In addition, 39.2% of persons with disabilities report that they spend between 626 AFAs (12 USD) and 4165 AFAs (85 USD)<sup>26</sup> on health care, compared to only 24.8% of non-disabled persons. This same type of difference is seen for the highest category of expenses, 4166 AFAs and above: here persons with disability are 17.8% to face such high expenses while non-disabled are only 3.9%.

*Health expenses of persons with disability can be considerable and can weigh upon the finances of the household*

When a person with disability accesses health services, 36.2% expenses made are for medication, followed by fees or donations (25.1%), and lastly 20.0% for transportation. Medication is the most frequent expense; this is why it is also the highest average expense. As shown in Table 5, the total average expenditure is between 3.6 (for mental disabled) and 5.5 times (for war survivors) higher for persons with disability than for non-disabled. This high level of disparity is observed for all categories of disability and by major causes as well. It is observed for all major types of expenses: transportation costs, fees, medication and medical tests.

**Figure 19. Distribution of Persons with Disability and Non-Disabled According to Health Expenses During the Year Preceding the Survey**



For some types of expenses, the gap between persons with disability and non-disabled is particularly high. For instance, landmine or UXO survivors spend 5.5 times more money on medication than non-disabled. Persons with associated disability spent 9 times more than non-disabled on transportation expenses. Even if the amounts considered are less, war survivors did spend 16 times more on medical tests in 2005 than the non-disabled.

Persons with disability all together spent an average of 1728 AFAs on medication in 2005, and Landmine/UXO survivors spent up to 3000 AFAs in average for this expense. Persons with disability all together spent an average of 608 AFAs for transportation, 200 AFAs for fees and 268 AFAs for food. The average total amount of expenditure is of 3459 AFAs for persons with disability considered as a whole. It is higher, especially for persons with sensorial disability.

<sup>26</sup> The exchange rate during 2005 fluctuated between 45 AFAs to a USD and 52 AFAs to a USD. Here we have calculated on an average of 50 AFAs to a USD.

**Table 5: Yearly Average Expenses (AFAs)**

Expenses	Types of Disability in 5 categories					Cause of Disability in 3 categories			Non-Disabled
	Physical Disability	Sensorial Disability	Mental Disability	Associated Disabilities	Epilepsy/ Seizures	Landmine/ UXO Survivors	Other War Survivors	Other Causes: Disease, Accident,	Non-Disabled
	Average Cost	Average Cost	Average Cost	Average Cost	Average Cost	Average Cost	Average Cost	Average Cost	Average Cost
Medication	1674.2	1950.5	2019.4	1230.3	1767.4	2912.7	2190.0	1595.6	531.2
Transportation	396.2	608.9	523.9	911.6	600.0	267.5	146.1	214.1	101.0
Fee	308.4	273.5	95.2	177.5	142.1	134.4	121.2	257.8	50.3
Tests	224.2	285.3	76.2	154.9	181.2	347.8	662.1	252.3	40.7
Food	266.8	496.6	95.6	247.4	234.3	579.8	612.8	538.9	33.4
Amulets	40.7	83.4	178.6	271.8	445.8	25.5	67.4	185.6	32.2
Caretaker	19.6	0.2	0.0	0.0	2.8	0.0	0.0	9.5	0.1
Equipment	0.1	0.4	0.0	5.2	2.8	0.0	0.0	1.4	0.8
Other	0.1	0.2	0.0	0.0	31.6	0.0	0.0	7.3	11.1
All Expenses	3516.5	4015.3	2998.6	3262.2	3505.9	4354.0	4598.2	3376.2	833.6

## Conclusions & Recommendations

### To Sum Up:

- Generally, barriers in ability to carry out daily activities are related directly to the type of disability the individual has. No unexpected obstacle has been identified in the ability of persons with disabilities to perform their daily self-care tasks within the household.
- Working in the fields and outside of the compound is a major concern for persons with disability. This can ultimately affect their ability to produce food and engage in income generating activities.
- Mental health is a significant challenge identified in this survey, especially for women.
- Persons with disability access health services regularly, particularly in the private sector, and, to a lesser extent health centres and hospitals. A large proportion of persons with disability resulting from unidentified causes turn to religion through mullahs to address illnesses. Lay beliefs regarding non-physical forms of disability are prevalent and often lead to a lack of knowledge regarding what can be done.
- Health costs are significantly higher for persons with disability.

### Steps Ahead:

#### Awareness Regarding Mental Forms of Disability

It is evident that a number of non-physical disabilities (especially mental form) that are believed to be caused by supernatural forces, djins and evil forces, are still cured by traditional methods and healers. Awareness regarding these is imperative in order to improve the living conditions of persons with disability, and fight harmful practices that can result from these beliefs. On the field, it was often noticed that there was a genuine concern for persons with non-physical disabilities, but often accompanied by a complete lack of knowledge regarding what can be done. The belief that these disabilities can be cured is still very strong which leads families to look for a “miracle” or “magical” solutions. Again, any campaign of awareness and sensitization would need to work on the beliefs and acceptance of a given condition, as well as try to avoid giving focus to the causes. Religious and community leaders are the major actors to get involved because of the influence and trust from which they benefit within communities.

Awareness regarding mental disability also needs to be strengthened within trainings for health professionals and workers.

### **Mental Distress is a Concern for Persons with Disability and Needs to be Addressed Urgently**

Therefore, the curriculum of doctors and other health workers should include knowledge about mental health. This is a major challenge for the Directorate of Mental Health in the MoPH. Health facilities staff needs to be equipped to address mental health issues. This problem is even more crucial when it comes to women with disability who show higher signs of anxiety and depression than men with disability. Gender sensitive initiatives (female health and social workers, specific health curriculum or specific section in all health services) need to be systematically incorporated into any programmes being designed. Lastly, it would be effective to address mental health in a concerted way through existing methods such as community and religious leaders and community health workers. Intervention should also make the family the focus for effective support<sup>27</sup>. Engaging religious and community leaders would need to be part of any strategy to provide health services to this population.

Certain steps can be taken in order to overcome barriers to access of public health services such as reducing distance to health facilities and cost:

- Accessibility to health services refers to physical accessibility, but not only to that. Access needs to be viewed in a wider sense starting with affordability, transportation facilitation as well as providing facilities for the person who accompanies the person with disability.
- Available generic drugs at the lowest possible price is also a challenge; if a good diagnostic is established but people cannot afford the cure, then the health situation of the population will not be improved.
- Setting up a referral system for disability and mental distress: this could be done alongside the training of various staff on disability. Bridges need to be built between the technicians and social workers who work closely with persons with disability on one hand, and the health professionals on the other. This would be a first step towards taking into account mental disability as well as psychological distress, which seem widespread in the country.

*Gender sensitive initiatives (female health and social workers, specific health curriculum or specific section in all health services) need to be systematically incorporated into any programmes being designed*

<sup>27</sup> GHOSH N., MOHIT A., and MURTHY R S., "Mental health promotion in post-conflict countries", *The Journal of the Royal Society for the Promotion of Health*, November 1, 2004; 124(6): 268 - 270.





# Towards Inclusion and Equality in Education

## From Assumptions to Facts

Many experts and institutions have an understanding of what the education situation is in Afghanistan. It is common knowledge that education of persons with disability in Afghanistan needs urgent attention in a context where policies are in the process of being set up and implemented. It is imperative to ensure that vulnerable groups are not left behind at this moment in time. In order to achieve goals within the disability and education sectors, precise knowledge is the first step towards ensuring that the necessary measures are taken to include persons with disability in the education process. There are a number of issues that arise when considering education for persons with disability. One of the main challenges is the definition of disability, which includes a wide array of impairments and conditions ranging from severe to mild. In addition, different types of disability have very different needs and requirements in terms of access to education as well as quality. Over the years, these considerations have been included in a number of international frameworks.

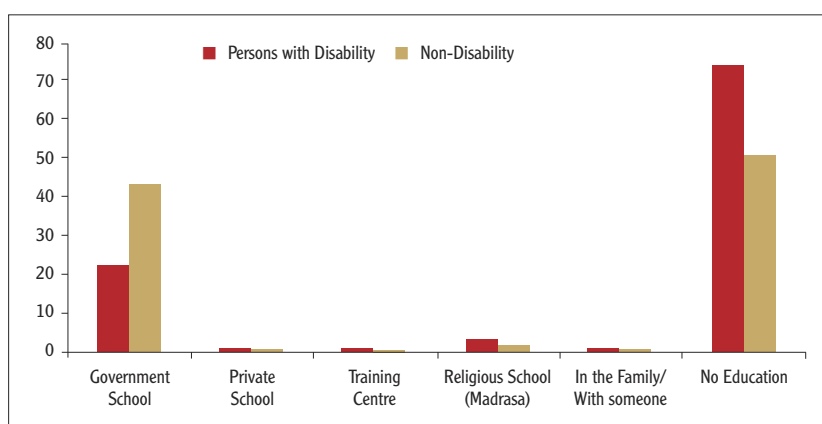
Data regarding the education of persons with disability in Afghanistan is presented through a set of indicators. This section will look specifically at access, retention, completion of education cycles, as well as literacy.

### Access to Education

The NDSA looked at access to some form of schooling, even if it was for a very limited period. This helps to comprehend whether the persons have received or are receiving some form of education. Access to education represents access to some form of schooling, even if it is for a very limited period. The NDSA looks at the access, which encompasses not just the children enrolled in school but also those who were enrolled, but dropped out. This section will present results regarding access, keeping in mind the age at which persons became disabled; if it was after the age of 7, then they will be considered along with the category of non-disabled since they were not yet disabled when they were at the age of accessing elementary education.

*One of the main challenges is the definition of disability, which includes a wide array of impairments and conditions ranging from severe to mild. Different types of disability have very different needs and requirements in terms of access to education*

**Figure 20: Access to Education According to Different Types of Schools**

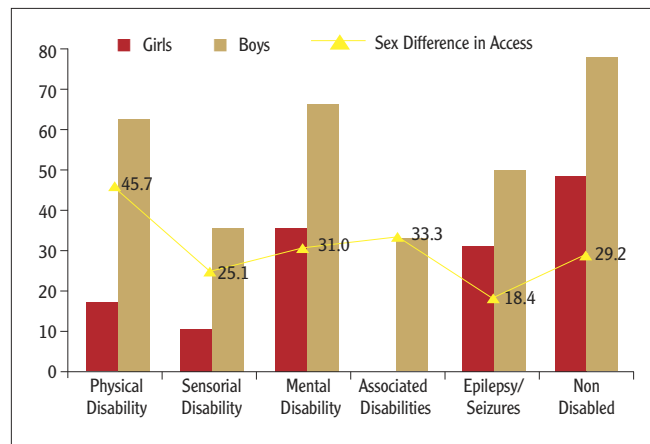


As shown in Figure 20, access to public education is remarkably and significantly different for persons with disability and non-disabled for the overall population. All together, almost 73% of persons with disability above 6 years old did not receive any education, whereas the rate is of 51.4% for the non-disabled.

A crucial aspect that influences access is the age at which a person became disabled. The overall access to public school is twice as high for non-disabled children than for children disabled before the age of 7 regardless of where they live, their sex or their generation. This result confirms that being disabled before school strongly influences access to any form of education.

Moreover, NDSA results show that the proportion of non-disabled children aged 7 to 14 accessing public school today is almost twice as high (64.2%) as the proportion of children with disability (35.3%): the gap is widening.

**Figure 21: Gap in Access to School According to Gender and Types of Disability for Persons Aged 7 to 14**

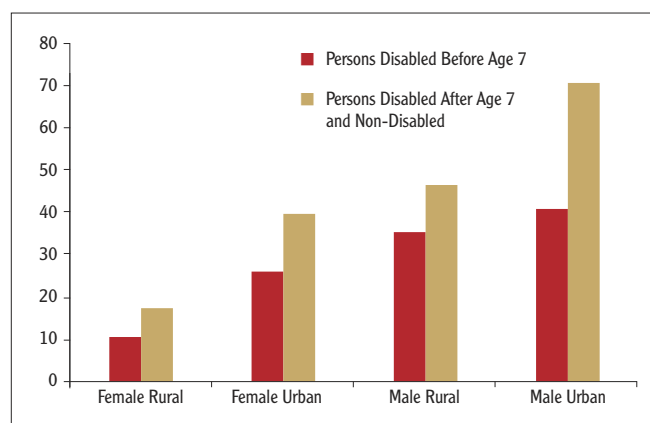


*Results confirm the huge overall gap regarding access to education between boys and girls*

Girls have less access to school than boys. Only 15.0% of girls disabled before age 7 go to school compared to 24.0% non-disabled women. There has been an improvement for non-disabled women over recent years: about 19% non-disabled women aged 15 to 25 accessed education in the past, whereas over 43% 7 to 14 year old non-disabled girls have access today. However, in the 7-14 age-group, when we look at the situation of girls disabled before 7, even if only 15.2% young girls with disability go to school, this proportion was almost non-existent in previous generations. Whatever the type of disability that a young Afghan girl suffers from, the probability of her accessing school still remains very low.

Results confirm the huge overall gap regarding access to education between boys and girls. This gap might seem more alarming when it comes to children with physical disability (45.7%): the main issue remains access of all girls to school. The gap that we observe with regard to physical disability can be explained by easier access of boys with these disabilities due to social norms of acceptability and minimal effort required within classes in order to include them within the education process.

**Figure 22: Access to Education According to Gender in Urban and Rural Areas**



The lowest level of access is observed for girls who became disabled before school-starting age, living in rural areas: 10.7% of these have access to school, as compared with an average of 17% for non-disabled girls living in similar settings. This needs to be compared to almost 40% for non-disabled urban girls. Although the numbers above show better access for girls, both disabled and non-disabled, in urban areas, the rate of 26.1% for access of girls disabled before age 7 is worrying, since this shows that girls are still excluded to a large extent from enrolment efforts.

*The lowest level of access is observed for girls who became disabled before school-starting age, living in rural areas*

Differences in access to school can be further understood by taking into account regional differences. As already stated, the main urban centres are providing easier access to schools for children than in the past, especially for boys. However, it can be assumed from this research that very remote areas are still lagging behind with regard to providing schools.

**Figure 23: Access to Education According to Age of Disability, Gender and Major Geographical Areas**

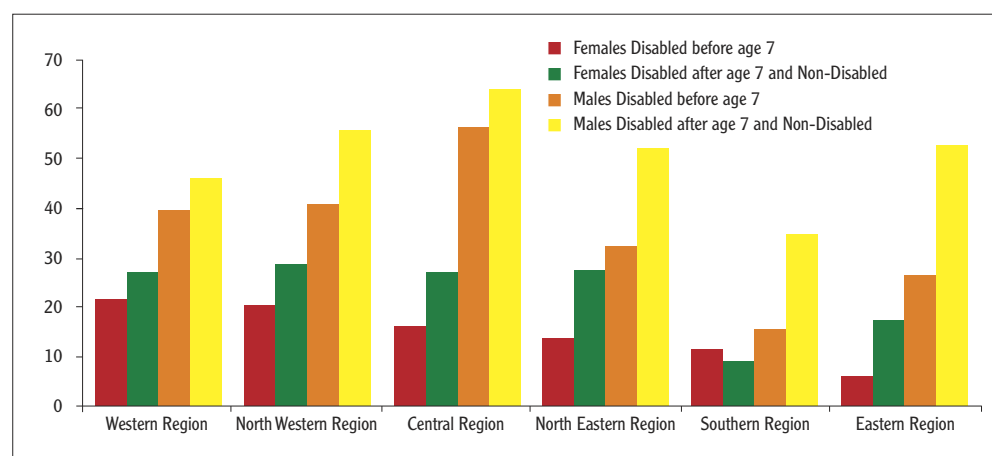


Figure 23 shows above the rates of access to school by regional areas for all people aged above 7 years old. These figures show that males have better access to education in all regional areas. Children with disability have less access than non-disabled: Southern and Eastern areas are the worst for disabled boys as well as girls. The figures are better in Western and North-Western areas.

However, if we look more closely at the figures in Table 6, it is the provinces where the main regional centres are situated, where access to schools is better.

**Table 6: Access to Education According to Age Groups, Age of Disability and Urban Regional Centres Compared to the Rest of the Country**

Age of Disability	Urban Centres <sup>28</sup>	Rest of the Country
Persons Disabled before age 7 (all age groups)	40.6%	26.2%
Persons Disabled after age 7 and Non-Disabled (all age groups)	62.2%	35.5%
Children between ages 7 and 14 who were Disabled before age 7	41.2%	34.7%
Children between ages 7 and 14 who were Disabled after age 7 and Non-Disabled	83.1%	60.6%

<sup>28</sup>The urban regional centres are : Kabul, Jalalabad, Kunduz City, Kandahar City, Herat City and Mazar-i-Sharif.

Table 6 highlights the advantage that large cities have over smaller cities and villages in terms of the existence of schools and access to them. However, the differences in access to education for children aged 7 to 14 who were disabled before school-going age in comparison to the others, shows an even wider gap between access in major urban regional centres (gap of 41.9%) than in the smaller towns and villages (gap of 25.9%). This confirms the trends that we have already described: educational efforts are not adequately reaching children with disability, and may even further increase the inequality of access if adequate measures are not taken.

## Retention, Transition & Completion

An analysis of education patterns within school provides an overview of the efficiency of the educational system.

**Attendance rate** is the rate of children of school-going age who are actually in school at the moment.

**Retention rates refer mainly to primary education.** To calculate these the proportion of children who have access to the first year of primary education and who are still in school during the last year of primary education are considered.

**Transition rates** are calculated at two different levels. Basic transition to and participation in secondary education refer to the proportion of persons who completed primary school and have accessed secondary education. Higher transition rates refer to the proportion of persons who complete secondary education and access higher education.

**Completion rates**, as the term indicates, refer to the completion of a cycle of education, be it primary, secondary or higher education. With household data and in the context of Afghanistan it is difficult to get verifiable data regarding completion. For the NDSA access to higher levels of education was considered as completion for primary education. Thus, any person who reached class 7 was considered to have finished primary education. For secondary education, calculating completion based on household data is even more complex as there is a very small proportion of persons who go on to higher education in Afghanistan. Therefore, the NDSA presents the proportion of individuals who reached class 12 as completing secondary education.

*The attendance rate is particularly high for non-disabled boys between 7 and 14 years old (76.8%), which corresponds to the usual age for primary school attendance*

**Figure 24: Attendance Rates by Sex and Age Groups for Persons with Disability and Non-Disabled**

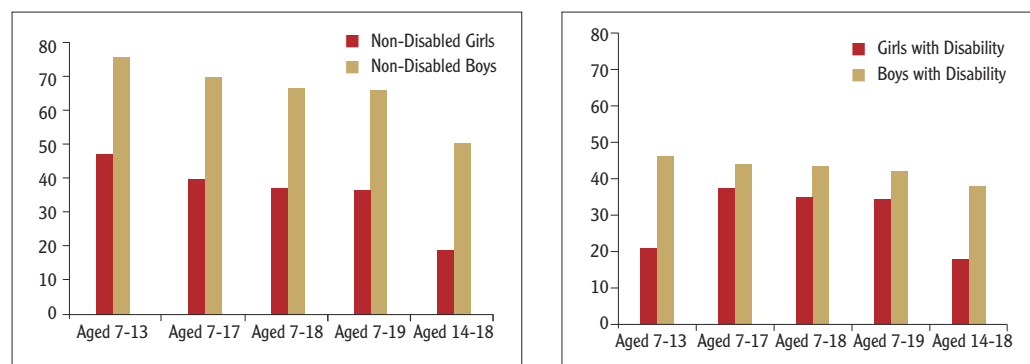


Figure 24 shows that the attendance rate is particularly high for non-disabled boys between 7 and 14 years old (76.8%), which corresponds to the usual age for primary school attendance. This rate remains quite high after 14 (more than half of the boys between 14 and 18) because boys who could not go to school during the war period started going to school after 2002, even if it was at a higher age. They started primary school between ages 8 and 15.

This phenomenon does not seem apparent for non-disabled girls. If there is a clear increase in attendance between ages 7 and 14 in comparison to the attendance rate for girls of this age group in the previous period, the rate falls considerably after 14 years old (19.7% of the 14-18 years old age group go to school). This is probably due partly to puberty and marriage, both leading the family to withdraw girls from school especially in villages where there are no female teachers. It is also due to the fact that schools recently opened in villages stop at class 6 or even before sometimes. Finally, another reason to be considered is that once girls have completed the primary level, they stop school. This may also be influenced by lay beliefs that girls do not need to be highly educated.

For children with disability, the situation is different. Between 7 and 14, their attendance rate is lower than for non-disabled children, especially for girls. If more than half (63.2%) of non-disabled children go to school, slightly more than a third of disabled children (36.1%) attend school. Among the latter, only 21.1% of disabled girls attend school at that age. After 13, the number of boys with disability going to school lessens (38.2% go to school), but the drop is considerable for girls with disability (only 10.9% aged 14 to 18 go to school).

**Figure 25: Retention, Transition and Completion for Persons Having Access to Education and According to the Age at which a Person became Disabled**

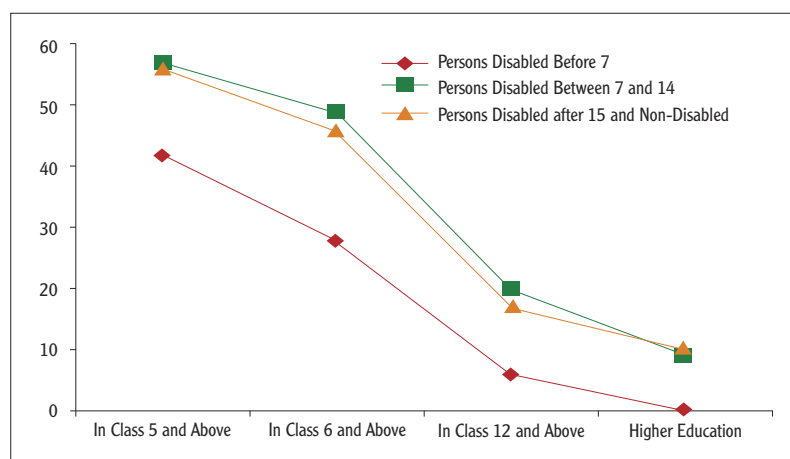


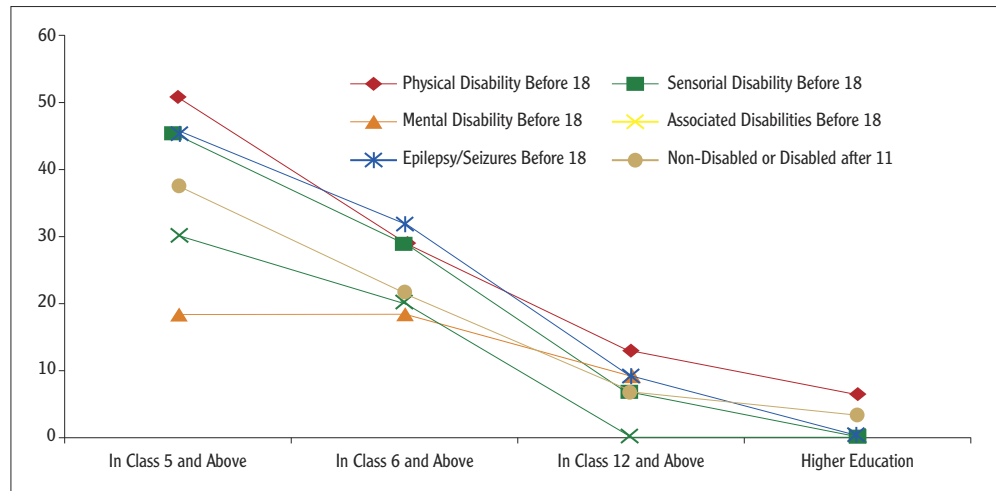
Figure 25 shows the level of education reached according to the age at which a person became disabled. There is a statistically significant difference between persons who become disabled at an early age (before 7) and face a problem of access to schools, and people disabled after school-starting age or non-disabled. It appears that children who become disabled when already in school have patterns similar to the non-disabled: persons who are disabled between the ages of 7 and 14 have similar retention and completion rates as persons disabled after 15 and the non-disabled: further breakdown between these categories does not yield any significant differences. Until the recent past, completion of secondary school and access to higher education has been very limited. The analysis also shows that the proportion of persons disabled before the age of 7 who went on to university is negligible.

The second factor that influences retention and transition is the type of disability that the persons has. Figure 26 shows results for persons who were disabled during their education years (before the age of 18).

The overall trends are similar for all types of disability as well as for non-disabled persons. The proportion of persons who finish primary school is not very high and the number of persons who actually finish secondary school is extremely low. If the various types of disability are looked at more closely, persons who have a physical disability during the school going years do better at the primary level than all the others including the non-disabled; this can also be related to the fact that a number of the physically disabled are boys, gender is

*The proportion of persons who finish primary school is not very high and the number of persons who actually finish secondary school is extremely low*

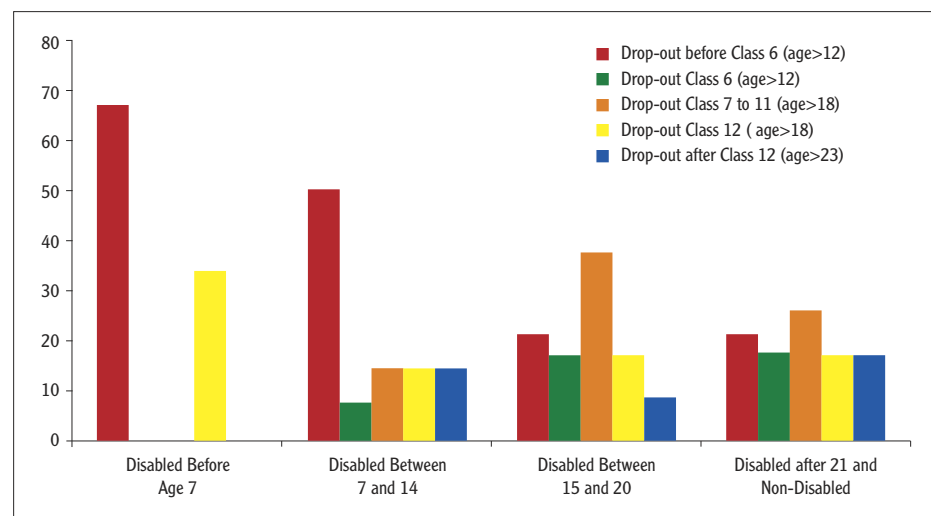
**Figure 26: Retention, Transition and Completion According to Different Types of Disability**



a major determinant. This can lead to the assumption that social norms of valorisation and acceptance do play an important role. Additionally, physically disabled persons have special needs with regards to access, but once in school the teaching methods are the same as the rest of the children. This is not the case for sensorial and mental disabilities where actually getting to school is not the major obstacle but the main challenge lies in the adaptation of teaching methods and the training of teachers. Sensitization of other children to their special needs is also an important element in order to fight stigma and discrimination.

Persons with mental and associated disability to stop schooling in the earlier stages constitute the highest proportion.

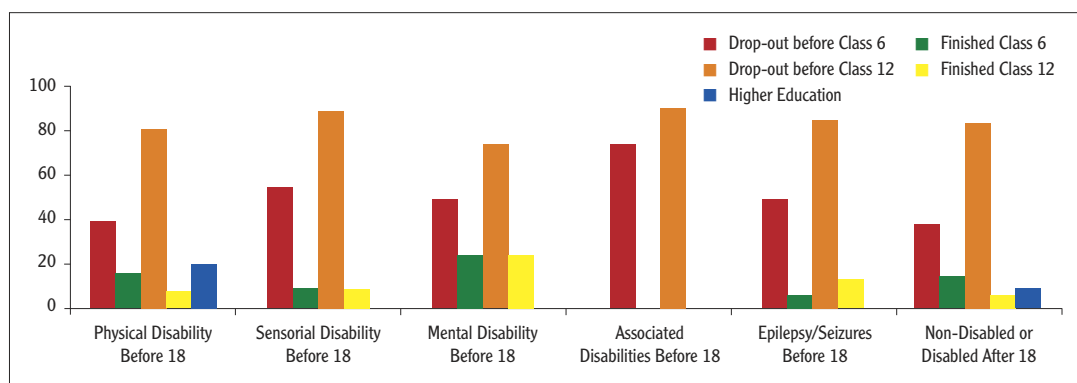
**Figure 27: Drop-outs According to Age of Disability**



Also, gender is a major discriminatory factor when looking at these results. The overall trends show that physically disabled boys have access and are retained in schools. The number of disabled girls is far lower.

When people become disabled before age 7 or are disabled during school years, the chances that they will drop-out before the end of primary school are high. There is no person who became disabled before school age and reached higher education level in our sample. If a person becomes disabled between ages 15 and 20 then he/she has a high chance of not completing secondary school. Impairment also has a negative impact on disabled students resulting in their stopping school due to their inability to follow class or even rejection by

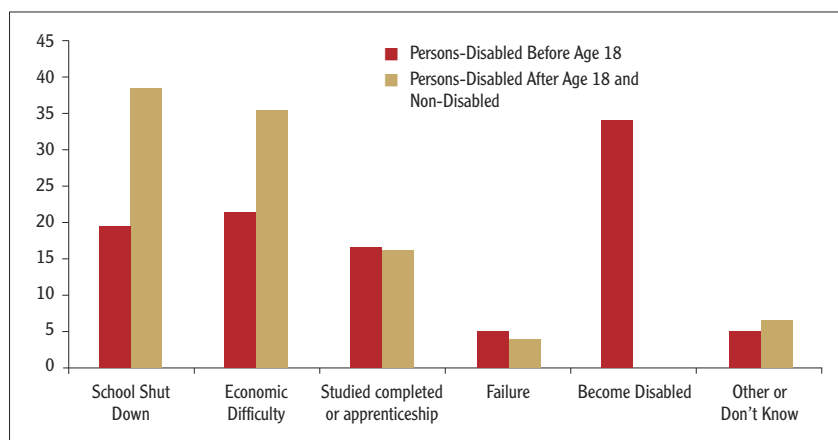
**Figure 28: Drop-out According to Types of Disability**



the educational system. Sensitization campaigns towards teachers and community should focus on the ways to retain children who become disabled while still in the educational process. However, Figure 28 shows that this issue is less a problem for physically disabled children, especially boys, than for children with other types of disability, specifically mental and associated.

It is important to notice that the majority of persons, disabled or not, drop out during the primary years. However, the drop out rates in primary school are the lowest for the physically disabled – even less than for the non-disabled. A closer look at the data set shows that those remaining in school are mainly boys. Huge retention efforts need to be made for all in addition to increasing access in primary schools regarding other forms of disability.

**Figure 29: Reasons Identified for Dropping Out of School**



There is a clear difference between the reasons why those disabled during school years and the non-disabled dropped out of school. For the first group, the main reason is their disability, economic difficulties and the absence or shutting down of school. For the non-disabled, the latter two reasons are primarily stated. It is still difficult to understand what lies behind this explanation “because of my disability”. However, since these persons did have some access to school, it is probable that the learning environment is not adapted to include children with disability. Close examination of the results shows two factors that play a role in the drop-out of children with disability. First the burden on the family (more for the physically disabled who need to be taken to school) and second the discrimination and prejudicial behaviour (more for mental and sensorial forms of disability) of parents of other children, classmates and teachers. These, combined with a lack of adapted material and sensitised teachers, make learning a real challenge for these children.

*There is a clear difference between the reasons why those disabled during school years and the non-disabled dropped out of school*

There is a strong belief that persons with physical disability can be included in mainstream education whereas those who have sensorial or mental difficulties need to attend specialised structures. Policy decisions will need

to take this into consideration when instituting measures regarding the education of children with these forms of disability. At present, the rare cases when they receive appropriate education is when there are schools, often run by NGOs that have specialised teachers, methods and materials. But these opportunities are very few and mainly located in large cities. Moreover, these structures are costly and very difficult to set up and sustain due to lack of adequate human resources. In the long run, the only sustainable solution is training of teachers to include children with disability in the mainstream.

## Effectiveness of Education: Literacy

Literacy rates are the proportion of persons who are literate in the overall population. However, in different countries, the means of assessing literacy vary from self-reporting, to merely writing your own name. This often results in overestimation of the literacy rates and a lack of comparability. The latest “Education for All Global Monitoring Report 2006: Literacy for Life” states that the global literacy rate is 81.9% (76.4% for developing countries and over 98% for developed and transition countries)<sup>29</sup>. The literacy rates for the NDSA, as in other surveys carried out in Afghanistan, are based on household data. All interviewees who were over the age of 8 were asked whether they knew how to read and write. If the answer was YES, then he/she was asked to write down a short sentence that was presented by the surveyor<sup>30</sup>. If the interviewee was able to write the sentences without much hesitation and completely then he/she was considered to be literate by the surveyor who wrote down his/her own answer.

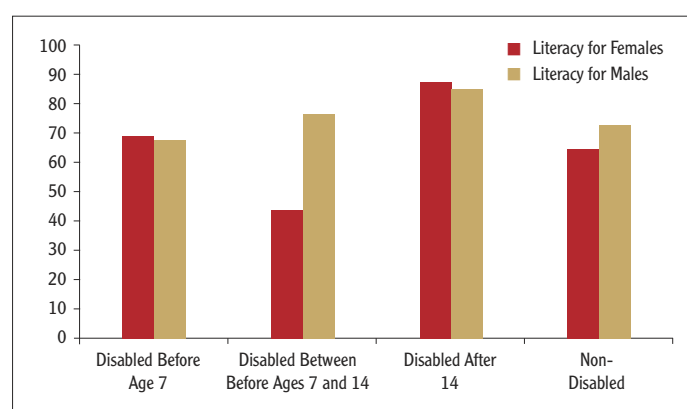
*When children do access to school and complete primary education, they effectively learn how to read and write*

**Table 7: Literacy Rates: Comparing Various Household Surveys**

Sources	Year of Survey	Overall Average	Average for Females	Average for Males
MICS (Persons over age 15) <sup>31</sup>	2003	22.2%	8.1%	36.1%
NRVA (Persons over age 6) <sup>32</sup>	2003	23.7%	10.3%	36.9%
NDSA (Persons over age 7)	2005	27.2%	15.1%	36.1%

There seems to be consistency between the various surveys that have been carried out in Afghanistan. The NRVA and the MICS present slightly lower rates than the NDSA. When children do access to school and complete primary education, they effectively learn how to read and write. This may be a reflection of the efforts that have been made in the field of education, especially over recent years. But, the gap between persons with disability and non-disabled remains a reality.

**Figure 30: Literacy Rates According to Age of Disability and Gender for Persons who Accessed Public School**



<sup>29</sup> There is no data for Afghanistan regarding these rates in the GMR 2006.

<sup>30</sup> The sentence that interviewees had to write down was adapted to their age.

<sup>31</sup> Multi Indicator Cluster Survey, 2003, op. cit.

<sup>32</sup> Ministry of Rural Rehabilitation and Development, Vulnerability Analysis Unit (2004), op. cit.

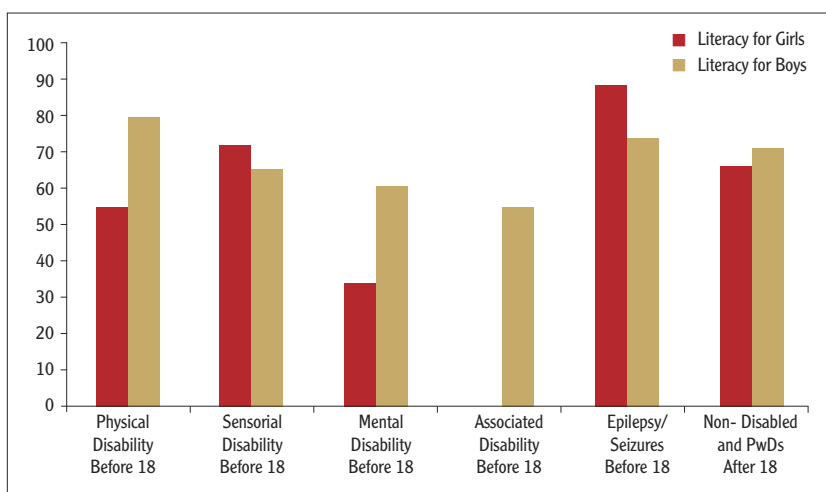


As we stated in earlier sections, the gender differences regarding access to school are considerable. So, when looking at the trends presented, this factor must be taken into consideration, as the number of girls accessing education is much lower than that of boys. However, once girls do access school they do learn to read and write. This is evident for people who are disabled before the age of 7 of which 68.0% girls as well as boys are literate when they have access to school. However, the literacy rate for women disabled between 7 and 14 is much lower (43.0%) than that of boys of the same category (76.0%). These figures suggest that at an age where girls are particularly vulnerable (puberty leads to a high level of drop-out), disability also affects learning skills.

*The gender differences regarding access to school are considerable. The number of girls accessing education is much lower than that of boys*

For persons disabled after age 18 (and who were not disabled at school-starting age) and the non-disabled, there is little difference between the literacy rates of girls and boys as shown in Figure 31. This appears to confirm the fact that despite the obstacles that girls face regarding access to education, once they do get to school they learn at par with the boys. These results also suggest that schools are effective and inequality is not aggravated in terms of learning outcomes.

**Figure 31: Literacy Rates According to Types of Disability and Gender for Persons who Accessed Public School and are Aged 10-18**



Physically disabled girls have a lower literacy rate than boys (gap of 24.1%). For sensorial disability, epilepsy and other forms of seizures this tendency seems reversed. Respectively 7.1% and 14.2% more girls are able to read and write than boys. However, the literacy rates for mentally disabled and non-disabled are similar; there is a slight gender difference to the advantage of boys. For associated disability, no significant data for girls was available for this age group. However, the gender differences reflect a complex situation where the specific needs related to various forms of impairment interact with gender-sensitive requirements.

## Conclusions & Recommendations

### To Sum Up Regarding Access:

- The proportion of non-disabled children accessing public school is almost two times higher than the proportion of children with disability.
- Policy makers' effort to send children back to school is not yet reaching children who became disabled at an early stage.
- In general, within all age groups surveyed, males have more access to school than females.
- At all ages, non-disabled women have less access to school than men who become disabled before school-starting age.

- Boys with physical disability are increasingly accessing school, whereas boys with sensorial disability or mental difficulty (with the exception of epilepsy) are lagging behind. For girls the main issue remains the access of all girls to school. The gap that we observe with regard to physical disability can be explained by easier access of boys with these disabilities due to social norms of acceptability and minimal effort required within classes in order to include them within the education process.
- In the main towns, for children aged between 7 and 14, the education effort has been considerable, but is not reaching children with disability, and is further increasing this inequality. It is obvious that where there is an absence of schools of any form in the area, the impact of disability on access is irrelevant. However, when structures do exist, the lack of access is attributed to the disability, before being explained by gender.

### To Sum Up Regarding Efficiency:

- When people did access some form of schooling, a majority of them learnt to read and write.
- Formal school systems achieve high literacy rates for children with disability as well as the non-disabled, which is encouraging.
- Gender differences are less regarding literacy than those observed regarding access. Results suggest that school contributes to reducing inequalities in terms of basic learning outcomes, the first one being literacy.
- Within schools, special focus needs to be given to children with sensorial disability who require more effort of adaptation of methods and teacher training with regard to learning to read, write and communicate in general.

*Gender is a complex factor to understand and to tackle through policies and programmes since it usually entails grappling with deep-rooted beliefs and cultural practices that cannot be changed overnight*

### Steps Ahead:

#### **Enhancing Equality Between Persons with Disability and Non-Disabled Persons: The Major Challenge Ahead**

The most disturbing finding of the survey with regard to education is that the efforts of different decision makers are not reaching persons with disability equally. One issue is the building of schools and structures. But here again, access needs to be regarded in the larger sense: physical accessibility, and ensuring that there is a school there to access, but access also concerns learning environments, teaching methods and facilities that exist. This is essential when we look at girls' education.

#### **Access to Education for Girls: A Serious Concern**

Gender is a complex factor to understand and to tackle through policies and programmes since it usually entails grappling with deep-rooted beliefs and cultural practices that cannot be changed overnight. The issue of education for girls will require a lot of thought and discussion among different actors involved, including the Ministry of Women Affairs. At school, sensitization towards girls and women's rights should start within the classes for all children. In general, at all ages, males have more access to school than females. At all ages, women without disability have less access to school than men who become disabled before school-starting age. The effect of gender is significant within almost all indicators that have been presented in this report. Gender seems to have more importance than being disabled in terms of access to education. The reasons behind these differences are many and inter-twined. They range from beliefs and cultural practices to distance of school, the availability of female teachers and adequate facilities such as toilets. These reasons need to be taken into account systematically and according to the specific needs. The need for consideration of the above issues is also evident when the reasons given for not sending girls to school are examined. A number of persons believe that schools are not for girls. This is in contradiction to the fact that a large majority of persons think that education is useful in general (over 90% of our sample). All of the above clearly shows that beyond making school accessible in terms of distance, facilities and teachers; a huge effort needs to be made in the area of gender stereotypes and gender specific attitudes. This should be done at every level including teacher training, curricula and material development, and teaching methodologies in order to encourage girls with disability to access education at par with other children.

### **Different Types of Disability, Different Access**

Boys with physical disability are increasingly accessing school, whereas boys with sensorial disability or mental difficulty (with the exception of epilepsy) are lagging behind. For girls the main issue remains the access of all girls to school. The gap that we observe with regard to physical disability can be explained by easier access of boys with these disabilities due to social norms of acceptability and minimal effort required within classes in order to include them within the education process. If we look at learning outcomes such as literacy, it is evident that within schools, special focus should be given to children with sensorial disability. These require adaptation of methods and teacher training to enhance the quality of learning. As access to education improves, it is plausible that certain other forms of disability will become more salient, such as learning and intellectual disabilities. At present these forms of difficulties are still hard to detect.



# Employment of Afghans with Disability

## Rates, Types, Barriers, Income from Work

After the long period of conflict, the economic structures and mechanisms have to be rebuilt in Afghanistan. Industry is almost non-existent, agriculture represents the largest sector for activity and services have been increasing at a fast pace since the last four years, at least in urban areas. Despite efforts made in the field, very little is known regarding the labour market situation in Afghanistan. To what extent do persons with disability have access to income generating work? What are the specificities of work for Afghans with disability? What is the proportion of persons in the formal and informal sectors? What are the main challenges that lie ahead in order to improve working conditions?

Before answering these questions, it is necessary to evaluate the level of employment, both of non-disabled and persons with disability. Unemployment is considered as the situation of a person without an income generating activity, effectively looking for a job and ready to take it immediately if an opportunity occurs. However, such a view would exclude a large number of persons who do work:

- In large areas of the country, women are not allowed to work in the field and are limited to household tasks. If we include women who take care of household chores and consider them as unemployed, then the unemployment rate is of 45.8% among the 15-64 age group. Only 2.4% of Afghan women, aged 15-64, are in fact looking for a job. The reality is more complex than this binary view. Some of the women are associated with a small job providing income alongside the main activity of household chores. Some also contribute to tasks like working in the field and attending to livestock.
- Another difficulty in defining employment rates relates to the complexity of the land ownership system and the diversity of status of people working on this land: landowners, mortgagers, tenants who share the crops, simple labourers (Kargar), etc. Beyond this complexity of the land system in rural areas, the ownership of land/house/property by a member of the household, remains reliable benchmarks for staying out of poverty<sup>33</sup>.
- Lastly, a number of services and work are not paid on a strictly monetary basis, or at regular intervals. This makes assessment of income from a given activity extremely difficult.

Lack of employment is a major barrier to personal autonomy and financial independence, especially for persons with disability who are at high risk of lifetime dependency on others. Employment also brings an increased value and respect within the family, as contributors and not a burden, consequently improving their social image and status. Identifying difference of employment situation and strategies and the link with different kinds of disabilities can help to identify inequalities. This information, in turn, can be of help to define development of programmes and employment policy.

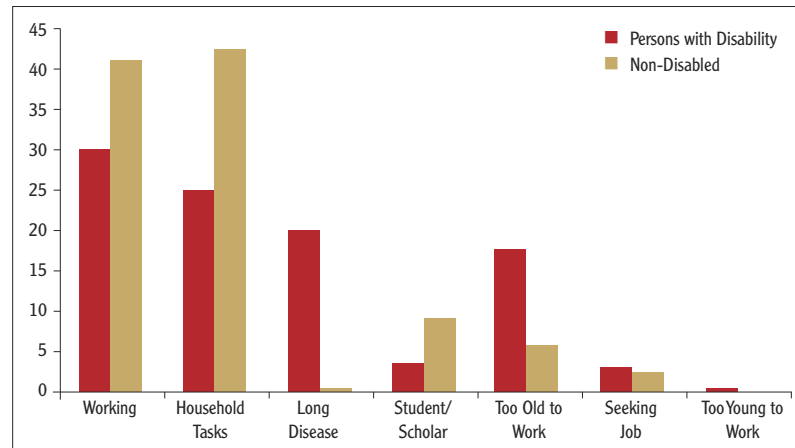
### Rate of Employment

To what extent are persons with disability employed in Afghanistan? Measuring the level of employment shows that active people represent 21.5% of the whole population and 41.4% if we consider the population aged 15 to 64, which corresponds to international standards. People in charge of household tasks, essentially women aged between 15 and 64, represent 43.3% of the population of active age (above 15 years old). This means that the inclusion or exclusion of women in charge of household tasks will strongly weigh upon the rate of unemployment.

*Lack of employment is a major barrier to personal autonomy and financial independence, especially for persons with disability who are at high risk of lifetime dependency on others*

<sup>33</sup> See ALDEN W. L. (2004); op. cit.

**Figure 32: Distribution of Persons with Disability and Non-Disabled Age 15-64 According to Employment Situation**

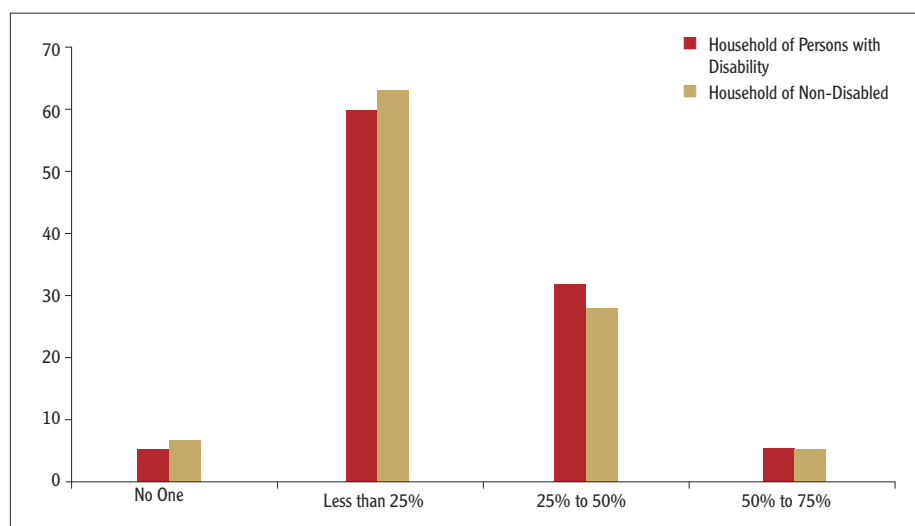


*The proportion of earning members in a household is a relevant indicator of vulnerability. The risk of falling (back) into poverty is lower when more people are financial contributors*

The employment rate is lower for persons with disability than for non-disabled in many countries, as is the case in Afghanistan. The difference of level of employment between the two groups is statistically significant. The same observation goes for people in charge of household tasks. Disability impedes both professional activities and household tasks. In the first case, men are more concerned; in the second, women are in majority. Moreover, 27.8% of persons with disability aged 15 to 64 cannot work inside or outside the house due to severity of their health condition.

The proportion of earning members in a household is a relevant indicator of vulnerability. The risk of falling (back) into poverty is lower when more people are financial contributors. Only a minority of households do not have anyone working. They rely on relatives outside the household for their subsistence and they are more at risk of seeing their situation worsen in case of unexpected events (illness, natural disaster, etc). There is no significant difference between households with person with disability and households with non-disabled persons. A large majority of both types of households reported having less than one fourth of their members employed. A higher proportion (62.6%) is observed among households with a person with disability than in non-disabled households (59.0%). This is an indicator of higher vulnerability to risks in the long term.

**Figure 33: Distribution of Persons with Disability and Non-Disabled According to Employment Ratio**



The ratio of employment in the household does not provide all the information about its level of vulnerability. The existence of women and children's work also gives an indication on the level of welfare of the household.

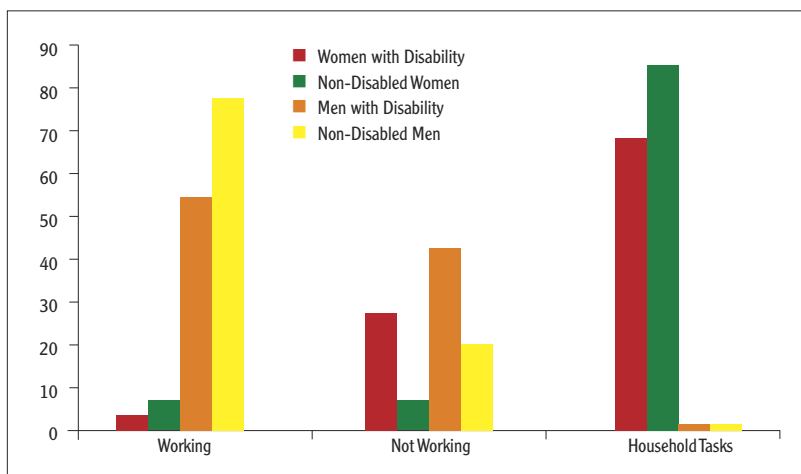
Activity level differs between men and women. The majority of persons with disability, who do not work due to the severity of their condition, are men. Reasons for women not working are not directly linked to disability.

In fact, Figure 34 shows that women aged 15-64, disabled or not, are very scarcely present in the labour market in income generating activities (only 9.0% are active). This is due to the fact that women are most often not allowed to go outside the house, especially for farming activities in the field. However, NDSA trends show that in urban centres, women more often participate in the labour market, especially when they are the only ones to support their families after migration or death of husbands or fathers: 12.2% work and bring an income to the family.

What is indisputable is the fact that women in Afghanistan are responsible for all household tasks: looking after children and elders, preparing meals, fetching wood and water if they are not too far, cleaning the house and the compound, etc. 90.0% of women aged 15 to 64 carry out all these tasks, which are physically demanding. In urban areas, only 77.3% do exclusively household related tasks, whereas in rural areas this figure is 89.9%. In urban areas, a few women are students, looking for a job or actually doing an income generating activity; however these numbers remain very low.

*Women in Afghanistan are responsible for all household tasks: looking after children and elders, preparing meals, fetching wood and water if they are not too far, cleaning the house and the compound*

**Figure 34: Distribution of Persons with Disability and Non-Disabled Age 15-64 According to Employment Situation and Gender**



The employment situation is even worse for women with disability. Results show that the proportion of women with disability who do not or cannot work at all and do not have the capacity to do household tasks usually carried out by women are 26.3% in urban settings and 24.7% in rural areas. This might, in turn, put at risk their chance of getting married, impact their position within the family and the community, and reduce the consideration that they have within Afghan society.

Sometimes alongside household chores, women carry out an income-generating activity or a few agricultural tasks: farming and herding livestock. Yet, in Pashto areas particularly, women are not allowed to farm and herd livestock. Therefore, the figure of 6.0% of non-disabled women working probably underestimates the exact level of activity of women, which remains very hard to assess.

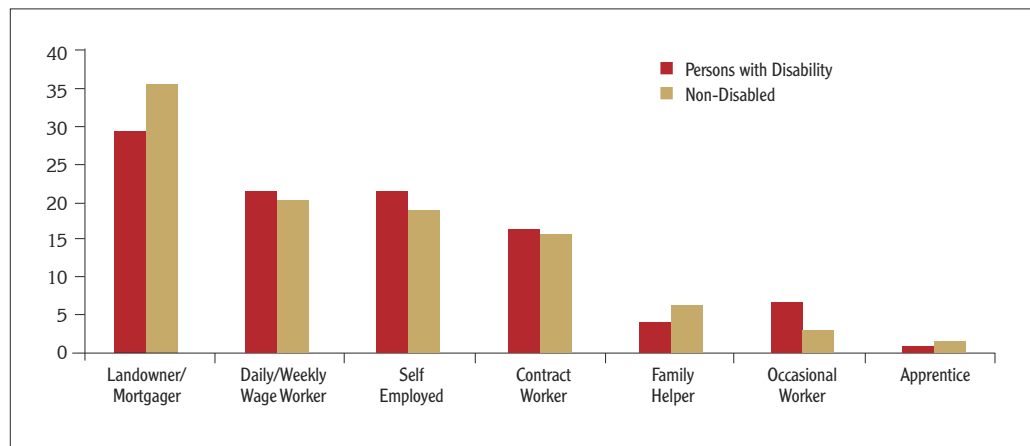
## Type of Employment

Around 35.7% of Afghans who report having employment, are owners, or have mortgaged the land they cultivate. Then come people having their own independent activity, who represent 18.6% of the active population. Considered together, it appears that more than half of the working population is composed of self-employed people. 15.6% are contract workers<sup>34</sup>, which is a rather protected status as compared

<sup>34</sup> A contract worker is usually employed with a contract and is paid on a regular basis. The contract can be written or can be a verbal agreement.

to others: usually they benefit from a monthly wage and they have well-defined working conditions: fixed working hours, fixed wage, specific tasks and working location. The rest of the active employed people come to 30.0% and have a more precarious working status: family helpers, seasonal and occasional workers, and daily/weekly wage workers<sup>35</sup>. Only 0.1% of active Afghans employ other people in their business, which barely represents a few thousand people.

**Figure 35: Distribution of Active People Age 15-64 by Employment Status**



A multitude of professions exists in Afghanistan. Dozens of professions were identified during the survey. Nevertheless, **the most common profession is farming (40.2%)**. Farmers are usually owners of their land or rent a piece of land from someone against part of the crop or/and a rent. Shepherds and labourers are other professionals of the agricultural sector, which represents almost 45% of all actives in Afghanistan.

Workers in the construction sector represent almost 10% of all active people. The importance of the reconstruction effort since the end of 2001 explains why many people find a job in building activities. People with a small capital open shop of various kinds and do small trade. The wealthiest open a shop (7.2% of actives); the poorest are street vendors (2.5%). Peace is also characterised by the renewal of travel and exchanges. A large part of transportation of goods and persons is done by road in a country where there is no railway and air transport is expensive. **As a result the profession of driver is quite common: 4.1% of the labour force.**

The government has become an important employer. The huge effort made in the education sector is evident considering the high number of teachers (3.2%). This profession is in rapid progress, not only in public schools, but also in a flourishing sector of private schools and vocational training centres (often run by NGOs) in many disciplines: languages (mainly English), computer skills, trade, craft, tailoring, secretarial skills, etc. Another 3% are civil servants in ministries, provincial departments, and other government offices. The security needs in the country explain that security services represent almost 2% of the active labour force.

When they have work, persons with disability occupy jobs that have more or less a similar status as the non-disabled. Persons with disability are less present in professions requiring physical strength, of course: farmers, construction workers, drivers, mechanics... Yet they are in significantly higher proportion working as street vendors, shopkeepers and other little jobs, with unstable wages and no status. **Non-disabled persons constitute a larger proportion of landowners or mortgagers, while persons with disability are more often occasional workers.** Persons with disability are also in slightly higher proportion in self-employed activities, which is often the term used for shopkeepers or street vendors.

<sup>35</sup> A daily/weekly wage-worker is usually employed for a very short period of time (often on a daily basis) without any contract specification. The persons can be a daily/weekly wage worker.

*Non-disabled persons constitute a larger proportion of landowners or mortgagers, while persons with disability are more often occasional workers*



## Children's Work

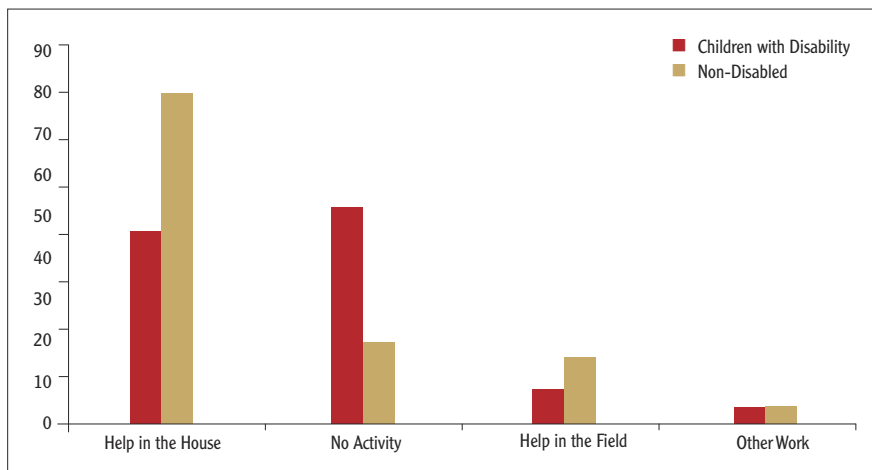
If children with disability are largely excluded from the education system, especially girls, not only due to prejudice and cultural rules, but also as a result of absence of adequate transport or accessibility of schools, a significant part of them take on household tasks, farming or other income generating activities of the family, just like all children in Afghanistan.

Figure 36 gives a general overview of children's activities. 60.0% go to school and 76.6% help with all household tasks: cooking, taking care of elders and younger children, fetching water and cutting wood, etc. 20.0% also have a professional activity mainly in the agricultural sector: animals husbandry, fieldwork, etc. Days can be very long for children.

Children with disability work less often than other children, especially in the fields; this is a direct consequence of their general inability to do so. They also help significantly less within the house. This is also explained by the physical demand of the work both in the field and in major household tasks such as fetching water, cleaning, cooking and cutting wood. This is why half the children with disability do not declare any kind of activity. Children, disabled or not, constitute a higher working proportion in rural areas. The difference between children with disability and non-disabled is statistically significant for household chores.

*Children with disability work less often than other children, especially in the fields; this is a direct consequence of their general inability to do so. They also help significantly less within the house*

**Figure 36: Distribution of Afghan Children with Disability and Non-Disabled Aged 6 to 14 Years Old According to Employment Situation**



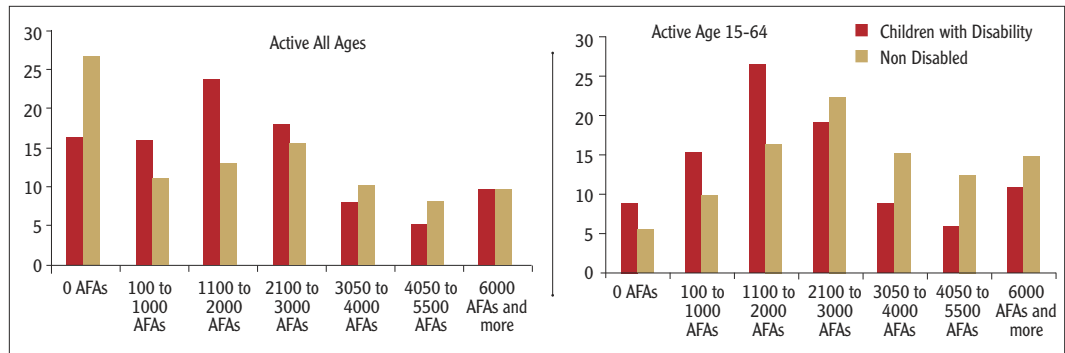
Note: Some children reported more than one activity, total not equal to 100%.

## Income from Employment

Comparing monetary income must be done with a lot of caution. Many active people, particularly children under 14, do not receive an individual wage (26.5%). Children's income is often included in the family income. The left graph in Figure 37 shows that many active people are not paid, especially the non-disabled (26.7%) compared to persons with disability (16.4%). This can be explained by a higher rate of employment among non-disabled children who contribute to the family income by participating in a large array of activities, mainly field work, for which the head of household gets the income. Employing children often means having to pay a lower income.

Adults with disability who earn no wage when they work are a higher proportion (9.3%) than non-disabled adults (5.9%). In high ranges of income (above 2000 AFAs), the graph on the right shows that the proportion of non-disabled adults is higher. But the level of disparity is not statistically significant for the highest level of income; it is, however, significant for the lowest levels (less than 2000 AFAs). Consequently, a majority (51.7%) of active adults with disability earn monthly wages under 2000 AFAs (40 USD) while 32.7% non-disabled adults earn the same. The majority of non-disabled earn 2100 AFAs and above. The phenomenon is even more noticeable for women: 91.7% of active adult women with disability earn less than 2000 AFAs a month. This is the case for 58.7% of non-disabled active Afghan women.

**Figure 37: Distribution of Active Persons with Disability and Non-Disabled According to Monthly Per Capita Income**



## Conclusions & Recommendations

### To Sum Up:

- The Afghan labour market is characterised by a dominant agricultural sector, which employs the majority of the Afghan work force. Men with disability are only a little more than a majority of working people. A large majority of women do not have income generating employment.
- On the other hand, children with disability aged 6-14 do work: they are just as many as non-disabled children in all jobs except fieldwork. Almost half of them contribute to household tasks.
- Persons with disability, when they participate in the labour market, are present in the same professions as other Afghan workers. Yet, they occupy the most precarious positions: occasional workers, family helpers, etc. They also earn lower wages, especially women with disability.
- Disabled men do not work due to their impairment. Finding the way to allow them to contribute to the family welfare by their activity is a step towards alleviation of poverty.
- Access to employment for persons with disability is an effective way to fight poverty, reduce vulnerability, and strengthen social inclusion. Whenever a person contributes to the family welfare, his/her social status within the family improves.

*Children with disability invariably contribute to household tasks, in the field or in other work. It is gender more than disability that affects their choices and especially their access to education. However, the main concern remains child labour*

### Steps Ahead:

#### Children's Work

Children's work is common all over Afghanistan. Children with disability invariably contribute to household tasks, in the field or in other work. It is gender more than disability that affects their choices and especially their access to education. However, the main concern remains child labour,<sup>36</sup> children who are earning income outside of the family circle and who are contributing to the running of the household. The NDSA, being a household survey, does not provide results regarding street children in big cities, who are cut off from their families. Specific measures will be needed to adequately comprehend and tackle this issue.

Promoting school for children is the best way to reduce child labour. However, it is a long process. By knowing to read and write, developing analytical skills and critical thinking, these children are more able to deal with their environment and get better working conditions in the future.

#### Social Valorisation and Acceptance Through Work

In a society where resources are scarce and living conditions are hard, access to remunerated activity remains the first factor towards changing age-old attitudes. This strongly challenges the belief that persons with

<sup>36</sup> Publications and documents of the International Labour Office define child labour as both paid and unpaid work and activities that are mentally, physically, socially or morally dangerous and harmful to children. It is work that deprives them of opportunities for schooling or that requires them to assume the multiple burdens of schooling and work at home and in other work places; and work that enslaves them and separates them from their family. This is meant by child labour - work carried out to the detriment and endangerment of the child, in violation of international law and national legislation.

disability are 'unable' to do something and must be 'aided'. Contributing to the family allows them to gain a status that they often lack; this, in turn, affects self-esteem.

Whenever they are able to work and provide for themselves, persons with disability must be encouraged and supported to do so. For men with amputations in far removed rural areas, artificial limbs can, in some cases, be the solution in order to work in the fields. Adequate training providing useful skills makes it possible for persons with disability to apply for more stable jobs.

### **Becoming a Contributing Member: First Step Towards Sensitization**

Campaigns of sensitization can modify the perception that a person with disability is a valuable member of society. However, a campaign based on rights alone cannot be effective in changing age-old beliefs in the long term. Helping persons with disability to access the labour market has an extensive effect on reduction of poverty: both persons with disability and their caretakers might work, leading to an increase in earnings and thus providing a way out of poverty. This also has a more lasting impact on the social perceptions of persons with disability as well as their self-perception.

### **The Government of Afghanistan can Set the Example in this Direction**

The government has to show the way for the rest of the society. An obligation of employment, of at least 5% of persons with disability in the public sector, if correctly and effectively enforced, is a strong impetus towards ensuring that persons with disability have an equal access to the labour market. However, going a step ahead would mean including persons with disability in mainstream labour market programmes (private and public) and activities wherever it is possible, as a priority group. Persons with disability should also be offered equal opportunities and full participation in programmes such as cash for work or food for work or the National Solidarity Programme of Afghanistan, that aim to provide jobs in projects undertaken at the community level. Promoting equal wages in the public sector and in the private formal sector is also a way to set an example.

*Persons with disability should also be offered equal opportunities and full participation in programmes such as cash for work or food for work or the National Solidarity Programme of Afghanistan*



# Livelihoods and Assets

## Poverty, Vulnerability and Disability

**W**hen we travel through Afghanistan, a general observation that can be made is the difficulty of ensuring means of livelihood, for a great majority of the population. The present overview of livelihood is only giving a few insights into poverty and vulnerability issues. Definitions of vulnerability and poverty vary widely and as a consequence, ways of fighting them are multiple.

Studying livelihoods of the Afghan population leads to taking into consideration monetary poverty. Absolute monetary poverty can be defined as the insufficiency of income to get the daily food ratio. Poverty, in terms of livelihood, is the paucity of adequate nutrition, lack of clothes, of accommodation, etc. The most common and traditional way of defining poverty is in terms of monetary income poverty.

However, recently the focus has also turned to poverty of potentiality, which is the lack of education, equipment, social networks and support systems. The means chosen to measure poverty, on which experts continue to debate, is as essential as the multiple meanings this word encompasses. Currently, economic policy choices, and the efficiency of these, depend on the accuracy and reliability of the tools used to collect relevant information. If focus remains limited to monetary poverty, this indicator has varied greatly and globally poverty measured by income has increased during the last 25 years in Afghanistan. If we look at the poverty of resources and of choices available in the larger sense, the country is characterised by a shortage of basic social services: shelter, water supply and sanitation, education, health, etc.

However, over the last decade, a more comprehensive view has emerged, mostly pushed forward by the Human Development Reports and the theories of Amartya Sen<sup>37</sup> to look at poverty in terms of capabilities. Amartya Sen's Capability Approach shifts the focus from what a person actually does (functionings) to take into consideration the range of possibilities that he/she chooses that specific functioning from – this is the capability set. Taking the view of the individual also brings into light the interaction between the person, with his/her limitations in functioning (which may or may not be permanent) and the context, which consists of a number of resources as well as expectations, stereotypes, and often, prejudice and discrimination. **As a result, looking at poverty of capability makes us look at not just what the person does but what his/her choices are. These choices are influenced by the social and human resources, especially in traditional cultural contexts. In these contexts disability consists in deprivation of capabilities that occurs when a person with impairment is deprived of possibilities, choices and opportunities.**

Because of this lack of capabilities, disability can lead to poverty as it creates constraints on the ability to work and the earning capacity. In Afghanistan, where 71.6% inhabitants live in rural areas, livelihood is based largely on agricultural activities. Having a disabled member increases costs of the household such as medical expenses. It might also prevent the caretakers from working or contributing to the earnings of the family.

In addition, poverty can lead to disability. Poor households do not have enough resources to satisfy their basic needs. Because they lack adequate food, basic sanitation, good housing or access to health, particularly preventive health services, poor households are more at risk of disabling diseases.

*If we look at the poverty of resources and of choices available in the larger sense, the country is characterised by a shortage of basic social services: shelter, water supply and sanitation, education, health, etc.*

<sup>37</sup> SEN A. (2000), *Development as Freedom*, Oxford University Press, Oxford

According to NRVA 2003, poverty is strongly correlated with disability in the household, among other attributes. Poverty is also correlated with lack of access to infrastructure and services, lack of access to school and health centres, lack of capital assets such as land and livestock. Land ownership is also a divider between the rich and the poor. This section of the report explores the link between disability and poverty, by comparing the situation of households with a person with disability and those without.

## Availability of Basic Commodities: Are Households with Persons with Disability More Deprived?

This present segment reports the results of the survey with regard to access of persons with disability and the non-disabled to food, water and latrines, all of which are important elements to ensure good health. Malnutrition, diseases brought about by water and lack of hygiene can also be causes of disability.

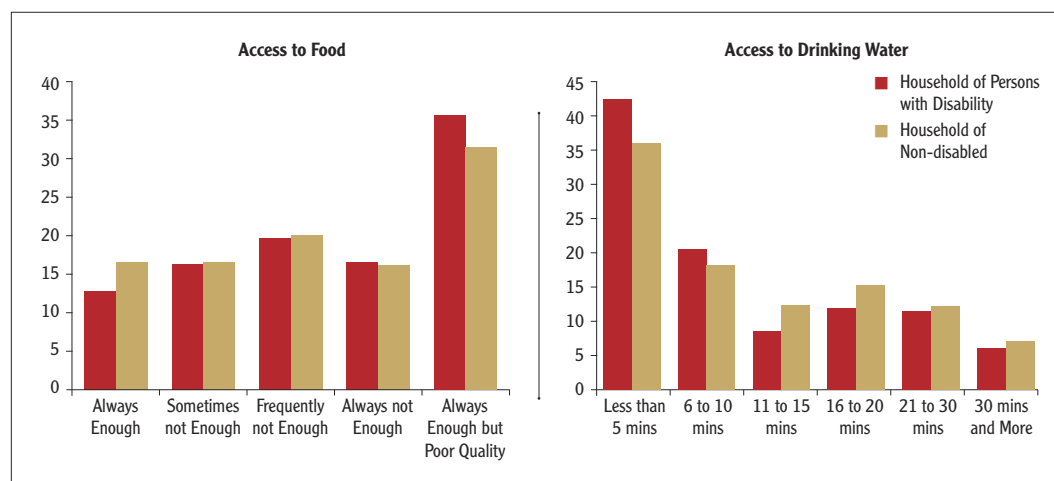
### Supply and Access to Food and Water: Is the Gap Significant?

If households with persons with disability are more at risk of falling into poverty, i.e., more vulnerable than other Afghan households, this should be illustrated by differences in access to basic goods and commodities.

When it comes to access to food (Figure 38), the majority of persons reported that their household did not receive enough food in general. The results are similar for persons with disability and non-disabled persons and there is no statistically significant difference between them. This could imply two things: first, persons with disability are not particularly deprived of food within the household. Second, these persons are deprived, but the general deprivation is so high that this phenomenon is over-shadowed by the overall shortage of adequate food.

A proportion of 16.2% in both groups stated that their households did not receive enough food on a regular basis, while 19.9% stated that they frequently did not have enough food. Among all households that declare having access to enough food, 31.5% stated that the quality was poor and the food was not diversified. Households with persons with disability are a statistically significant higher proportion (35.4%) in terms of access to poor quality food compared to households without a disabled person (31.2%). Thus, it seems that a higher proportion of households with persons with disability are vulnerable to inadequate food supply. Proportions of households with and without persons with disability professing to receive 'always not enough food' are similar.

**Figure 38. Distribution of Households with Persons with Disability and Households without Persons with Disability According to Access to Food and Water**



Sometimes, in the dry season, it is necessary to walk one entire day to go and fetch water from a river or lake. In case of drought, the situation might be even more dramatic. Inadequate access to water constitutes a major burden and strongly influences standards of living. In 2003, according to NRVA results, only 24.0%

*The majority of persons reported that their household did not receive enough food in general. The results are similar for persons with disability and non-disabled persons and there is no statistically significant difference between them*

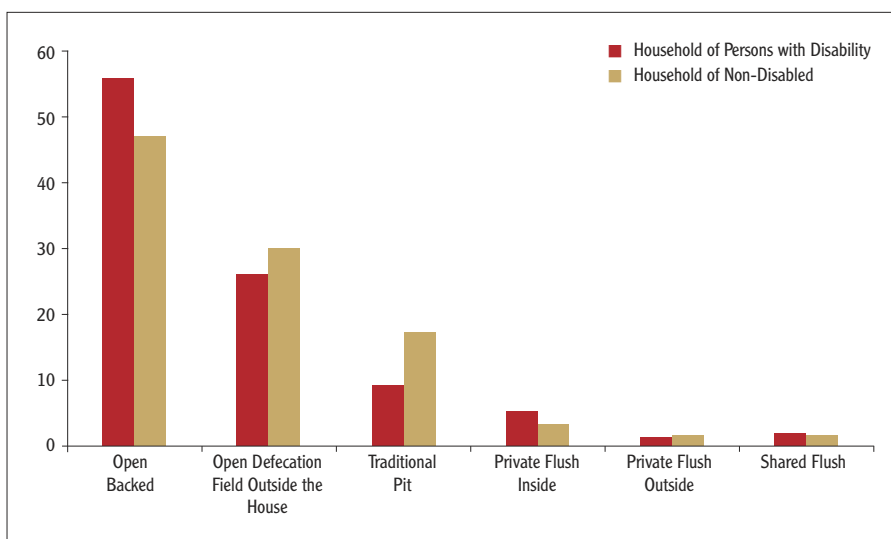
households reported accessing water from safe sources. Figure 38 looks at the distribution of households of persons with disability and of non-disabled regarding access to drinking water based on the NDSA. The responses are similar for households with persons with disability and for non-disabled households. A large majority of people in Afghanistan (74.3%) have to go outside the compound to fetch water. Nevertheless, households without any person with disability were proportionately higher (5.6% more) reporting having to go outside the compound. If only a minority (6.8%) needed more than half an hour to fetch water, a small proportion in rural areas (3.0%) required more than an hour and a half. Disability is not a significant factor of difference for access to drinkable water between households. Less than 6% of both groups of households receive their drinking water from a pipe supply. Another 23.6% obtain water from a public hand pump. One in four respondents receives drinking water from a river or stream, and another 15.8% from a spring. The difficulty in accessing clean and drinkable water constitutes a threat for health. Households with persons with disability are not particularly more at risk than households with no disabled members.

*Access to safe drinking water is absolutely out of reach for almost all the population. A large number rely upon natural sources of water*

### Toilet Facilities: A Risk for Health

A very small proportion of people have access to flush toilet facilities in the house (7.6%). A large majority of people use traditional types of latrines, usually outside the house. Lack of hygiene, a direct consequence of scarcity of water, can pose serious threats to health. The households of a majority of persons (53.2%) use a traditional open-backed latrine. This is followed by 27.1% households making use of an open defecation field outside their houses. There is no significant difference in access to latrines between households with a person with disability to those without a person with disabilities as shown in Figure 39. As expected, Afghans have more access to flushes for their natural needs in urban areas, while open fields are naturally more used in rural places.

**Figure 39. Distribution of Households with Persons with Disability and Households without Persons with Disability According to Access to Toilet Facilities**



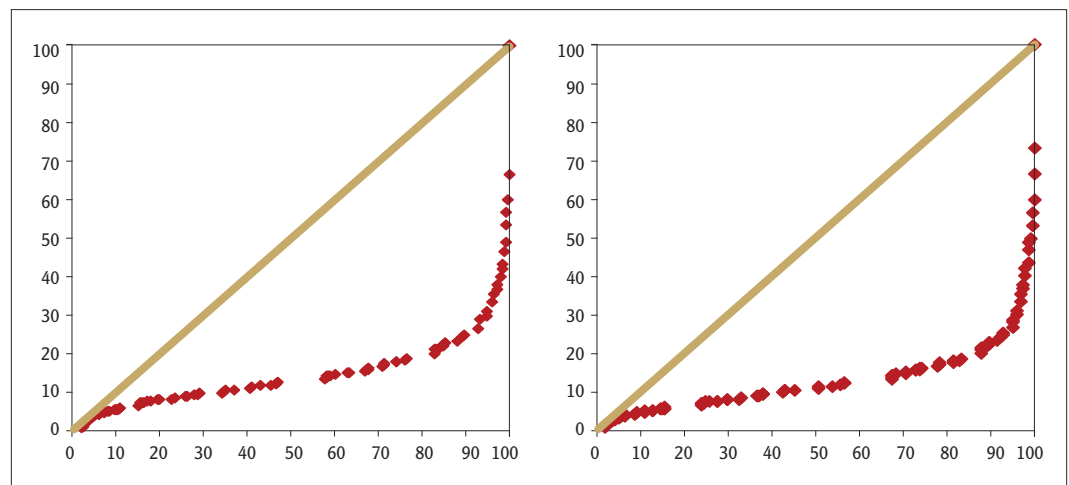
As a conclusion, Afghan people have poor access to diversified food, sometimes even to a sufficient quantity of food. Access to safe drinking water is absolutely out of reach for almost all the population. A large number rely upon natural sources of water. In case of drought, they are immediately at risk of shortage of water, sometimes leading to travelling an entire day to find water. Lack of hygiene is a serious concern with regard to the way people deal with their natural needs.

### Size of the House: Overcrowded Spaces

The average size of a household is a little more than 8 people (8.24) living in the same house, under the same roof, preparing food in the same kitchen, sharing meals, income and expenses as shown in Figure 40. A majority of people (57.1%) live in a space of 1 to 3 rooms. Compared to the average size of a household, this

means that the average living space is one room for three people. Small size of households is more common when the head is a woman.

**Figure 40: Cumulative Distribution of Household of Persons with Disability (left) and Household of Non-Disabled (right) Regarding Number of Members per Room in the House (Lorenz Curve)**



But inequality of size of household is important and well represented by the Lorenz Curve showing the cumulative distribution of households according to the number of members by room. The equality distribution (same number of people by room in all households) is represented by a diagonal line, and the greater the deviation of the Lorenz curves from this line, the greater the inequality. Households of persons with disability seem to be more overcrowded: the average number of people by room is higher for household with persons with disability.

*The level of debt can either be a factor of vulnerability, leading to poverty, or, on the contrary, a way of drawing on social resources to achieve certain functionings and increase capabilities*

## **Debt and Donation: Assets or Factors of Vulnerability?** **Level of Debt: Higher for Persons with Disability**

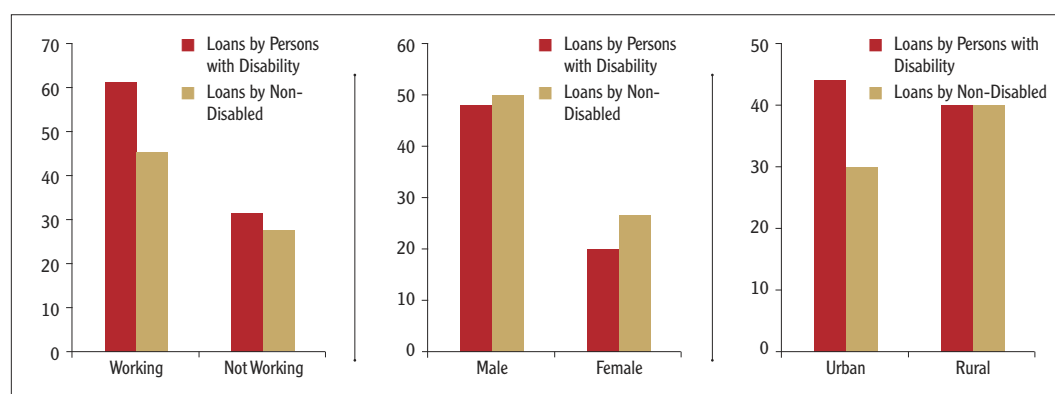
The level of debt can either be a factor of vulnerability, leading to poverty, or, on the contrary, a way of drawing on social resources to achieve certain functionings and increase capabilities. In fact, as loan is often a family matter in Afghanistan, if a person or his/her relatives cannot face his/her obligations of repayment, there is a propensity towards selling or mortgaging assets to pay back the debt. Around 35.8% of all Afghans aged over 14, female and male, have taken a loan, whatever the amount might be, in the 5 years preceding the interview. Figure 41 shows that borrowing is a common practice, especially if we consider that the loan is often taken for a family need and is paid back by all the active people in the family.

What are the characteristics of debt of Afghans today? Understanding these will help us to evaluate the risk of falling into poverty for the people in debt and assessing how vulnerable they may be. One major aspect is that people who lend money do not often ask for interest. Even if usury is a forbidden practice in a Muslim country, it is important to note that the mortgager gets back the amount lent, even if successive generations have to pay it back.

A majority of active persons report having taken loans (46.2%) as shown in Figure 41. Nevertheless, more than a quarter (27.6%) of people who are not currently employed have also taken loans in the last five years. Among these, a large proportion of people looking for a job have taken loans (55.9%), followed by older people (52.9%) who do not work anymore but have different sources of income coming from house rent, field rent, etc. There is a statistically significant difference between persons with disability taking a loan (36.1%) and non-disabled (30.5%). This difference is even higher when we consider active people: around 60% active persons with disability are indebted compared to only 45.7% active non-disabled.



**Figure 41: Distribution of Persons with Disability and Non-Disabled Above Age 14 with Loan Subscribed since 5 Years According to Activity, Gender and Area of Living**



The fact that women and youngsters provide little direct income to the family, because they are less often earning an income, explains that they are less likely to go into debt. Often, the man who is head of the family is the person who goes into debt because he is the person who collects all the income of the household and is considered responsible for paying back the debt. Usually when a child is working but still living in the household, even married, he/she gives his/her income to the head of household, but the requirement to repay the loan is shared by all members of the family.

**Figure 42: Distribution of Persons with Disability and Non-Disabled Above 14 According to Level of Debt**

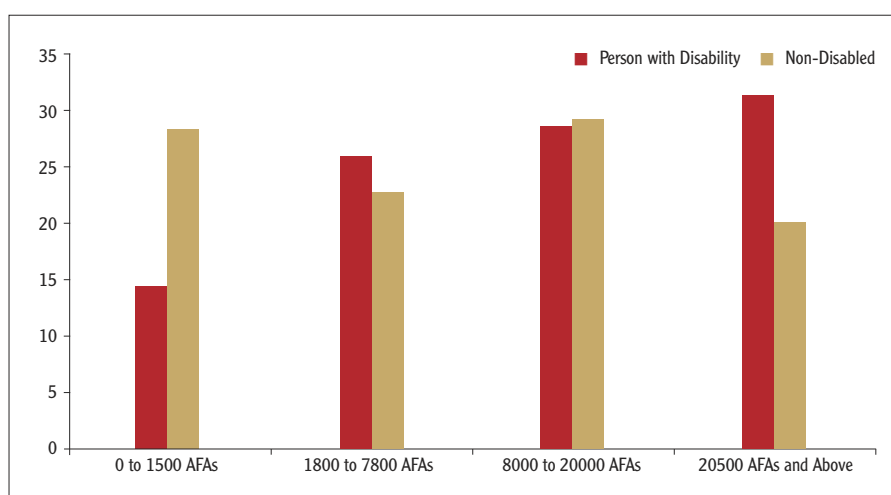
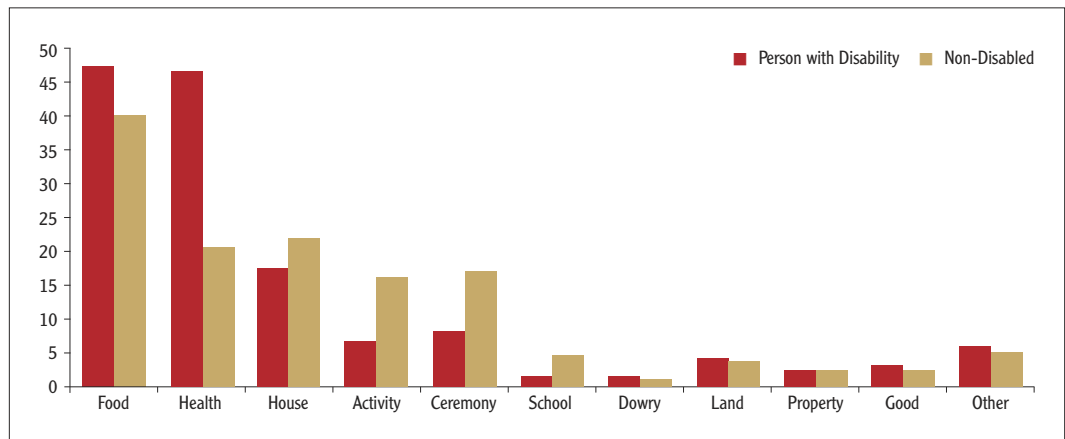


Figure 42 shows a significantly higher proportion of persons with disability with a high level of debt: while 20.0% of non-disabled people have a debt of over 20,000 AFAs; the proportion is 31.0% among persons with disability. If one bears in mind that the annual wage of a medical doctor working in a public hospital is less than 30,000 AFAs (600 USD), this is clearly a very high level of debt.

Is there a difference between persons with disability and non-disabled concerning the reasons why a loan has been taken? In fact, a major and statistically significant difference is for health expenditures: persons with disability, because of their health needs, more often take a loan to cover such expenditures, whereas non-disabled persons take loans more often to cover professional equipment purchase or for expenditures for religious or social ceremonies. Persons with disability more often use loans for food, while non-disabled persons use it more often for professional purpose (15.8% of non-disabled, 6.7% of persons with disability) or house equipment (21.9% of non-disabled, 17.0% of persons with disability).

**Figure 43: Distribution of Persons with Disability and Non-Disabled Above 14 and Purpose of Loan**



Whereas persons with disability usually use loans for emergency expenditures to cover basic needs such as nutrition and health, non-disabled have a tendency to use loans more for professional investment, equipment or social expenditure. There is a clear difference between persons with disability and non-disabled persons regarding reasons for loans. For the former, it is more a matter of urgency, to fulfil basic needs: thus it is a factor of vulnerability. For the latter, it is more of an investment in the future. Thus, it contributes to the welfare and the increase of assets of the household.

### Money Given: Family at the Basis of the Social Capital

If income from activity is concentrated in the hands of a small proportion of persons, redistribution within the family is a common practice in both groups. 43.2% of all adults above 14 received money from the social network, mainly family. There is no significant difference between disabled and non-disabled, when it comes to receiving money, even if a larger proportion of persons with disability receives money more frequently (a proportion of 45.4% compared to a proportion of 38.9% for non-disabled). One difference, which is noticeable, is that women receive help more often than men. This is consistent with the fact that men are the ones who have paid employment and bring the majority of money into the household.

Figure 44 shows a breakdown of persons with disability and non-disabled according to the person who gave money. In both cases, a huge majority of the donors are from the family itself. For non-disabled persons, first come the parents (28.9%), followed closely by the spouse (27.8%), then come brother and sister (23.2%) and children and other relatives, as a distant fourth (10.9%). For persons with disability, first come children and other relatives (24.6%), before brother and sister (22.6%), the spouse (19.7%) and parents (17.9%).

The differences between both groups are statistically significant. The major difference regarding the money received by children is probably due to the needs of persons with disability to get support. This is also in line with other findings of the NDSA, which shows a high number of persons over the age of 45 among persons with disability. The children thus support their parents as they become disabled with age and/or disease.

A minority of people receive money from persons outside the family. Friends make up a proportion of 5.4% in terms of giving money. Then come other donors, like NGOs or employers, mainly for persons with disability.

*There is no significant difference between disabled and non-disabled, when it comes to receiving money, even if a larger proportion of persons with disability receives money more frequently*

**Figure 44: Distribution of Persons with Disability and Non-Disabled Above 14 Receiving Money**

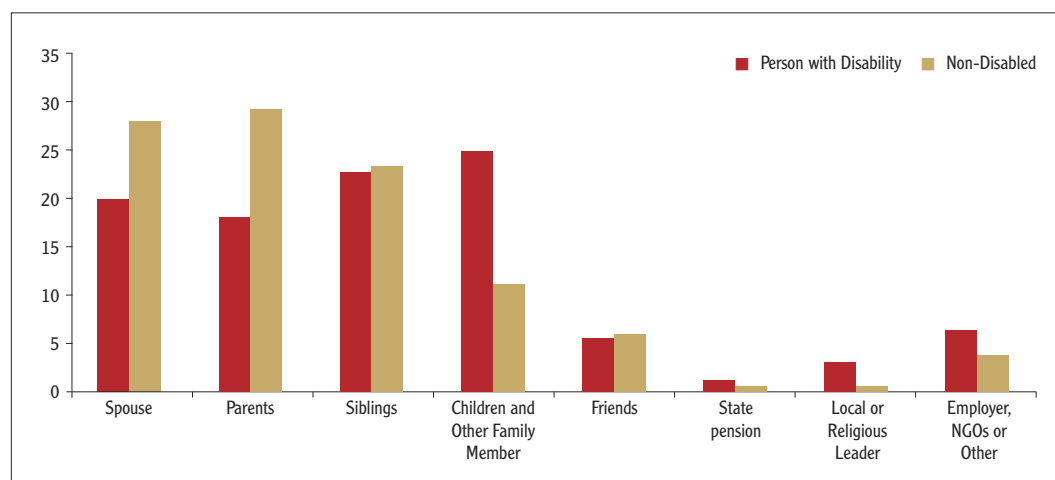
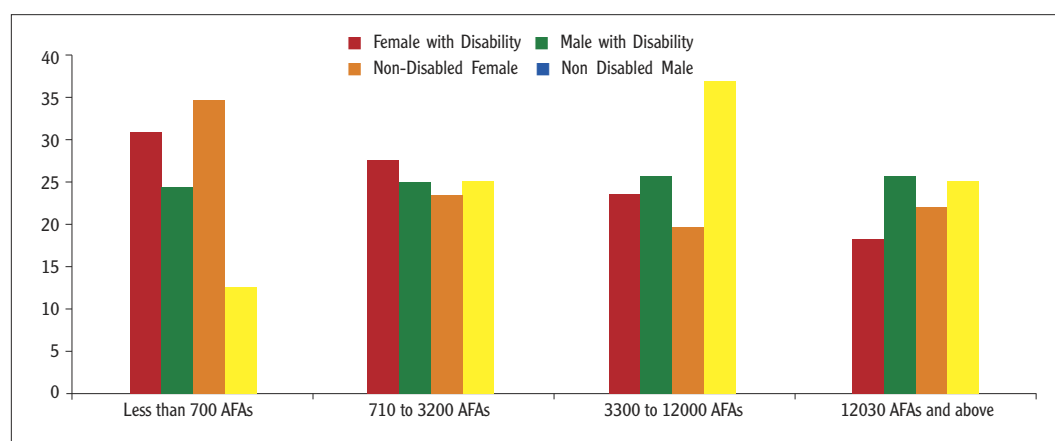


Figure 45 shows that males more often receive higher amounts of money than women, independently from the disability factor. 58.6% non-disabled women and 58.3% disabled women receive less than 3,200 AFAs (64 USD) a year. Furthermore, more than 25% males, disabled or not, receive more than 12,000 AFAs (240 USD).

**Figure 45: Distribution of Persons with Disability and Non-Disabled Above 14 Receiving Money by Amount and Gender**

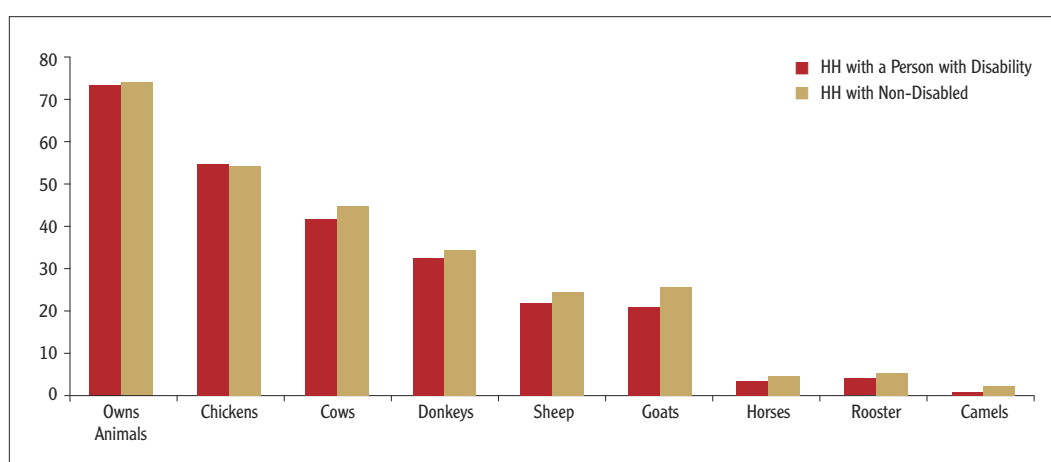


### Ownership of Livestock: Equality

The analysis in terms of households with persons with disability and households without persons with disability leads to similar conclusions concerning ownership of livestock. A large number of both groups of households possess livestock (See Figure 46). Yet, it can be noted that households without persons with disability have a slight tendency to own livestock that are expensive and considered more valuable, such as cows, horses, donkeys, roosters and camels.

Nevertheless, inside the household, ownership of land and animals tends to be concentrated among the males. Accordingly, households headed by a woman do less often own land and livestock.

**Figure 46: Distribution of Households of Persons with Disability and Households of Non-Disabled According to Possession of Livestock**



## Conclusions & Recommendations

### To Sum Up:

- Access to basic commodities and housing conditions do not show that circumstances are worse for households with a person with disability: there is no significant difference among the poorest between households of persons with disability and households of non-disabled. The gap is wider among households headed by a man and those headed by a woman. When one considers the less vulnerable households, households with persons with disability are a lesser proportion than those of non-disabled.
- Loan can be considered both as a factor of risk and as a factor of empowerment. It can ensure for some people a capability asset, whereas for others it represents a transitional survival...
- The loan amounts also show the link with vulnerability. People who take the highest loans are not the poorest but the ones who need to invest for the future or cover a special need. They usually have the capacity to pay back. They use a larger social network of friends and relatives to cover their needs. Elder men offer more guarantee of security. The loan system seems to be based on the social capital. Reimbursement must be ensured, so higher income is also an asset. More vulnerable people such as persons with disability and women take loans but they cannot benefit from the same network: they rely on parents or children (especially for women heads of households), and brothers (for persons with disability). Higher amounts of debt without the resources to pay back, or having someone's help in case of need, becomes a major burden. In this configuration, debt might be a factor of higher vulnerability. This is probably the reason for which women without disability do not take high loans. This also may explain why women who are heads of households, or disabled women, particularly in debt, are more vulnerable, with unexpected expenses to face. As a result they try to meet urgent needs by taking loans and hoping to find a way to pay back later.
- As expected, men give money more often to the members of their social network, particularly to their spouses. If they are a lower proportion in terms of receiving money, they nevertheless receive higher amounts than women. Donation of money is also part of the financial dependency of women on other males of the family. Women are not allowed to work, especially in rural areas, so men provide the resources for their needs. If they inherit part of the family land, they hand it over to the male of the family (sister to a brother, widow to a son) against a commitment of the latter to cover her needs.

*Finally, poverty appears as a "great leveller". Disability does not have an impact when the general population is faced with severe and chronic poverty*

Finally, poverty appears as a "great leveller". This is evident in some of the findings of this report. This can be said with regard to commodities, living spaces as well as other assets. Disability does not have an impact when the general population is faced with severe and chronic poverty. Lack of water, electricity and general commodities for the overall population leads to a very minimal difference between households of persons with disability and non-disabled households. Persons with disability are not necessarily the poorest of the

poor. On the contrary, low levels of living standards are shared on an equal basis by all. An exception is the case of women, especially isolated, who suffer from even greater discrimination and appear to be among the poorest. This has been highlighted both in towns and rural areas.

## Steps Ahead:

### **Rural-Urban: Reducing the Gap in Living Conditions**

Looking at the picture from the point of view of the household units, urban living standards seem to be a little more advantaged: better access to water, main power, flush, diet diversity, more equipment, larger size of houses and households, etc. Unlike Schutte<sup>38</sup>, who found more widespread nuclear households in Herat, urban households seem to be more extended according to the NDSA results. However, some trends do suggest that as urban lifestyles evolve, there is a possibility of the breakdown of social networks and support systems to draw upon.

### **Female-headed Households: Addressing the Most Vulnerable and the Poorest**

Households headed by a woman are both the poorest and the most vulnerable. This finding corroborates the NRVA 2003 analysis that identified such households among the poor and very poor wealth groups. As shown by the NRVA 2003, NDSA 2005 finds that women head of household are a higher proportion having an income generating activity. These households have lesser assets as well as poor nutritional diversity. They also face more isolation, and thus, are not able to rely on a strong social capital in case of shocks and unpredictable events.

Households headed by women are more present in urban areas, probably because of isolation from the rest of the family who is in the village. Tolerance for women heads of households might be also higher in major towns and the social expectations a little less salient. Hence, Afghan society maintains a strict control on honour of women who must conform to traditional rules. As Dupree writes, “the hierarchical structure within families leaves little room for individualism, for senior male members, the ultimate arbiters, maintain family honour and social status by ensuring all members conform to prescribed forms of acceptable behaviour<sup>39</sup>”.

### **Chronic and Multifaceted Poverty**

It is essential to focus upon the few results that have been found regarding the small proportion of the population that is better off than the majority. The trends observed lead to the belief that with regard to livelihoods and living conditions, disability impacts the more advantaged social groups. This, in turn, leads to the strong assumption that as conditions in general improve, the impact of disability becomes salient. In other words, as households get out of poverty, households that have a disabled member will have to face more difficulties and need more resources in order to improve their living conditions. Disability is thus a ‘dormant’ factor that is not on the forefront when we look at serious poverty. However, at the second stage, this factor may have a heavy impact by keeping certain households more vulnerable to poverty and less equipped to face risks in life.

As a conclusion, it can be said that the difference between households with persons with disability and households without persons with disability is not significantly observable among poor households, but that it becomes more important among households, which are better off. This leads us to believe that poverty is often chronic and multifaceted, influenced by a number of variables. Disability affects living conditions once all the other factors have been tackled, making persons with disability more vulnerable and more at risk of remaining in poverty. Thus, it is necessary first to fight poverty and then to ensure security and increase capability by reducing vulnerability of households that have a disabled member.

*Households headed by a woman are both the poorest and the most vulnerable. These households have lesser assets as well as poor nutritional diversity*

<sup>38</sup> SCHUTTE S. (2006), Poverty amid Prosperity: Urban Livelihood in Herat, *Afghanistan Research and Evaluation Unit Report*, AREU, May 2006, 61 pp.

<sup>39</sup> DUPREE N. H. (2004), The Family during Crisis in Afghanistan, *Journal of Comparative Family Studies*, vol. 35, 311:332.



# Social Participation and Future Prospects

## Determinants of Inclusion and Exclusion

The conclusive section of this Executive Summary Report is somewhat different from the previous ones. No Ministry or other government body is specifically assigned to tackle the issues stated here; however these issues, omnipresent throughout society, strongly influence all other fields and may be used to explain many of the findings presented in earlier sections.

The social representations of disability, the lay beliefs and practices affect the participation or rejection of persons with disability within the family and the community. These common beliefs are related to what persons with disability can or cannot achieve and what they can hope for. Moreover, what others expect them to be and do can enable or prevent persons with disability from having good self-esteem and confidence for the future. As a result, social perceptions of disability cannot be ignored and will invariably come into play in all spheres considered: these beliefs are present in health centres and hospitals, they are shared by teachers and educators as well as persons working within the various government structures of the country. Any programme set up to address the needs of persons with disability will have to integrate ways to challenge certain age-old beliefs and overcome the social barriers that prevent full participation of disabled people in society.

This section will look more closely at two main inclusion/exclusion mechanisms in Afghan culture:

- Access to marriage;
- Participation in religious and social celebrations within the community.

Finally, some findings regarding the outlook that persons with disability have for their future will be presented.

### How does Disability Affect Access to Marriage?

Family, and more specifically the extended family, is the main traditional structure in Afghanistan. The head of the household is usually the oldest male in the family. Sometimes, when the latter is not present or cannot work anymore because of his old age, one of his children or brothers becomes head of the household. Therefore, in some cases, the head of household can be very young. However, after over two decades of conflict “traditional value systems have been reinforced in some ways and broken down in others. For example, ethnic identity has become more important while the extended family system has tended to collapse when many husbands are killed, leaving thousands of widows”.<sup>40</sup> Thus, many widows became heads of households at a young age.

Regardless, marriage is a major step in the process of gaining a rightful place within society. Marriage is also linked closely to the ability to contribute to the family and the community in general. Contributions are different regarding men and women. In order to get married, men have to show the ability to gain a living and financially support a family. In fact, they have to collect a certain sum of money in order to pay for the

*Social perceptions of disability cannot be ignored and will invariably come into play in all spheres considered: these beliefs are present in health centres and hospitals, they are shared by teachers and educators as well as persons working within the various government structures of the country*

<sup>40</sup> COLERIDGE P. (1998), op. cit.

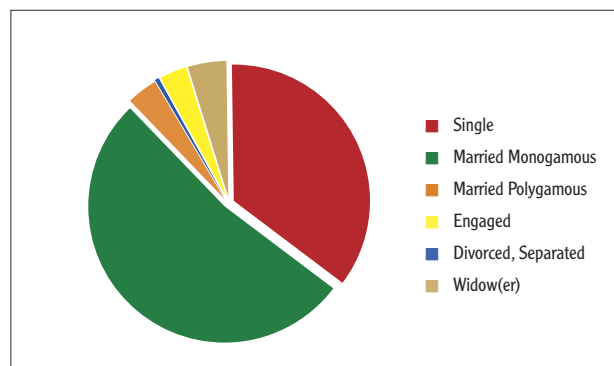
*The inability to bear children is a major determinant factor for social consideration and respect within the family and the community. As a result, when persons are considered to have congenital forms of disability or have mental disability, this ability is seriously questioned*

wedding and thus demonstrate their capability to take charge of a family and gain status as the head of household. Women, on the other hand, are expected to bear a large number of children and to take care of the members of the family: children and elderly people. If any of these expectations are not met then the person is not considered ‘marriageable’. A qualitative study carried out in 2004 by Altai Consulting clearly states: “once a disabled person cannot fulfil (their assigned) role, his/her position in society changes. This is noticeable in many ways: loss of respect within the family, loss of respect within the community, eventually not being able to marry, finally not being able to have offspring”.<sup>41</sup> The inability to bear children is a major determinant factor for social consideration and respect within the family and the community. As a result, when persons are considered to have congenital forms of disability or have mental disability, this ability is seriously questioned: the inability to marry and have children is a major exclusion mechanism. This is even more so in the case of women.

Bearing in mind the importance of marriage, it is not surprising that the proportion of married persons is very high and starts at a very early age. A large majority (56.4%) of Afghans over the age of 11 are married. Only 35.4% of this age group is still single, while the rest are widow(er), separated or divorced. The legal age to get married is of 16 for girls and 18 for boys. Nevertheless, some of them are already married before this age:

- 2.9% of girls before 16 and 2.1% of boys before 18 years old are married;
- 5.4% of girls before 16 and 3.8% of boys before 18 years old are engaged.

**Figure 47: Distribution of Afghans Above 11 Years Old by Civil Status**



The situation is a bit different between persons with disability and non-disabled. The over-representation of persons with disability in age classes above the age of 45 explains why widows and widowers are over-represented among persons with disability.

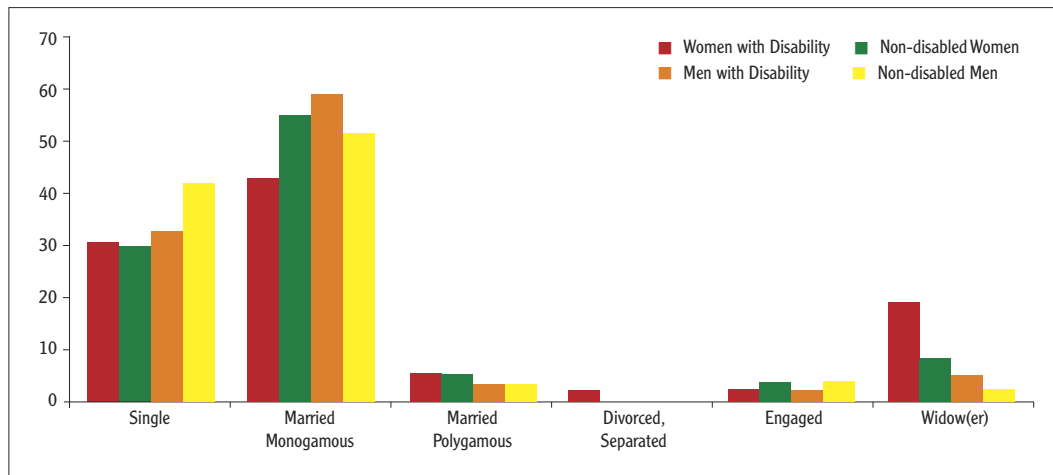
Men with disability are more often married (61.5%) than non-disabled men (53.6%). This can be explained by two main reasons. First, men are more often disabled by war-related causes and have physical disability. As a result they do have better social status and consideration within society. Second, a high proportion became disabled after marriage. The situation of women is not the same: women with disability are less often married (47.7%) than women without disability (59.4%).

These trends do suggest that disability is seen as an impediment to taking charge of a family, for women especially. This belief is closely linked to the aspects that were explained above: a woman’s contribution lies in the ability to bear children and look after other members of the household. Moreover, in case of sterility or if no children have been conceived after a certain number of years, the man can take another wife. The stigma of being barren is most often borne by the woman, and is often attributed to the fact of being disabled. “In

<sup>41</sup>THAKKAR M., CERVEAUT., DAVIN E., (2004), op. cit. p. 26



**Figure 48: Distribution of Persons with Disability and Non-Disabled Above 11 Years Old by Civil Status and Sex**



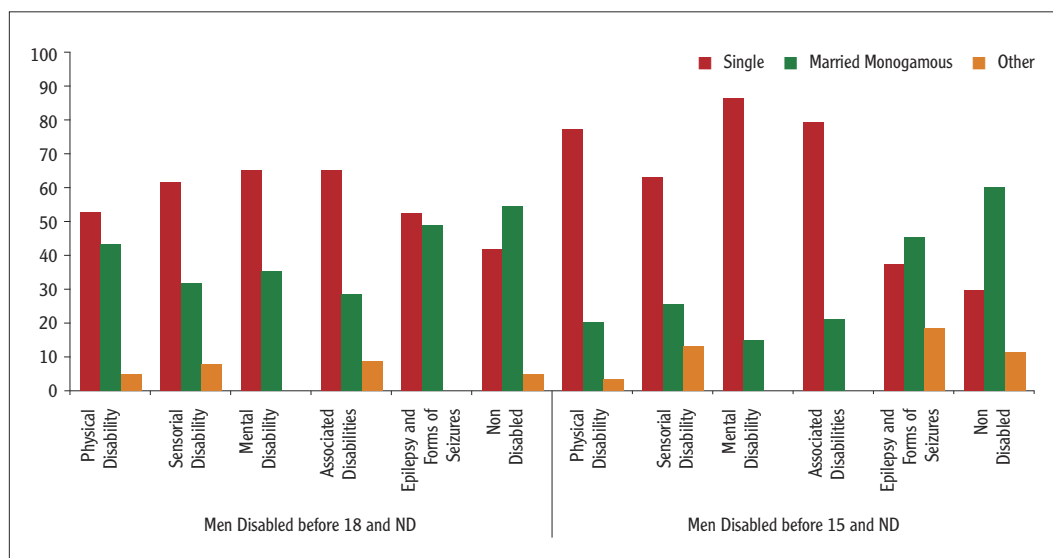
Afghan society, the expectancy on women to bear children cannot be overemphasised. And this is a challenge that women with disability have to face: they are also perceived as reproductively challenged and incapable of taking care of children. Usually, women with disability either are not married, or are married to a lower social class relative or another disabled person.<sup>42</sup>

The analysis of the NDSA shows certain results that confirm that characteristics of civil status vary depending on types of disability.

With the exception of men with associated disabilities, all men with disability are more likely to be married than non-disabled men. This is also due to the higher age of the disabled population. But men with physical disability are the highest proportion (66.2%) to be married. The proportion of married men is even higher among war survivors (77.9%). They are also those who are more often polygamous (5.1% and 2.7% for non-disabled men). This confirms the social recognition that war survivors enjoy in Afghan society.

*With the exception of men with associated disabilities, all men with disability are more likely to be married than non-disabled men. This is also due to the higher age of the disabled population*

**Figure 49: Distribution of Persons with Disability and Non-Disabled Above 11 Years Old by Civil Status, Types of Disability, Sex and Age at which a Person Became Disabled**



<sup>42</sup>THAKKAR M., CERVEAUT, DAVIN E., (2004), op. cit. p. 27

The situation is somewhat different for women. The proportion of women above 11 who are married is similar to the one of men for non-disabled women (54.3%), and it is double for polygamy (5.1%), which corresponds to an average of two wives for each polygamous man. Getting married and having children are essential components of social acceptability for women in Afghan culture. However, women with physical, sensorial, mental and associated types of disability face difficulties in getting married. Only women having epilepsy or some other form of seizures, are often married.

An essential factor to be taken into consideration is the age at which a person became disabled.

The results show that among women aged 11 to 25, the proportion of non-disabled already married (38.6%) is a lot higher than among young women with disability (between 4.5% for sensorial disability and 13.3% for physical disability). The only exceptions again are women with epilepsy or some other form of seizures who are a very high proportion (54.8%) in terms of getting married at an early age. Among older disabled women, widows constitute a high proportion. Figure 49 furthermore shows that:

- Men and women with disability are, in both cases and for all types of disability except epilepsy, less likely to get married than non-disabled men and women when they became disabled before the average age of marriage in Afghanistan (18 for men and 15 for women).
- While 53.5% of non-disabled men and 59.4% of non-disabled women aged above 11 are married, the figures are slightly different according to gender. For men, disabled before the age of 18, the chances of getting married are higher for the physically disabled (43.0% are married) than for other categories: 31.9% of those with sensorial disability, 35.3% of those with mental disability and 28.0% of those with associated disability.
- For women the marriage picture is the grimmest for those who became physically disabled before the age of 15: only 20.0% are married, in comparison to 30.3% of those women with sensorial disability, 30.4% of those women with associated disability and 36.8% of those reporting epilepsy/seizures. 23.1% women having a mental disability before the age of 15 are married.

As stated earlier, physical disability for men does not directly challenge their ability to earn a living. Moreover, physically disabled men, especially those disabled due to war and its consequences, are visible groups who have a place and consideration within society. A number of Disabled Persons' Organisations (DPO) have been created and are ruled by former Mujahidin who are war survivors. Special efforts are being made to ensure income-generation and economic integration for them. On the contrary, when women become physically disabled, their contributing role within the family is strongly challenged: more specifically their ability to bring up children.

## Inclusion or Exclusion in Community Celebrations

Social acceptance is paramount in determining the quality of life of persons with disability, even more so in traditional societies where family and community are the main support systems. The position and consideration within the family and the community will determine a series of other factors, such as self-esteem, access to education and receiving proper health care in case of need. "It is very difficult (...) to determine what the words 'social integration' mean in a context where segregation occurs within the private space of the home and where women in many Afghan communities only interact socially at rare events such as weddings and funerals".<sup>43</sup>

Communities in Afghanistan are closely knit and the year is punctuated by a number of celebrations. The participation of persons with disability within these various ceremonies can be considered a sign of certain acceptance and respect within the society. This is probably where the perceptions of the causes of disability come in: those who are perceived as having made a sacrifice for the country or as victims of war injuries are

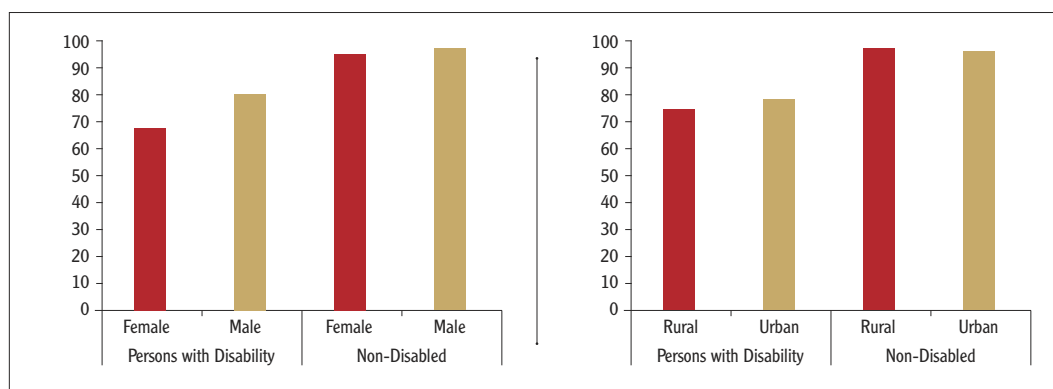
<sup>43</sup> COLERIDGE P. (1998), op. cit.

*Social acceptance is paramount in determining the quality of life of persons with disability, even more so in traditional societies where family and community are the main support systems*

considered to have a rightful claim within the community and earn the respect of their peers. It is needless to say that these are mostly men.

However, there is also the charity model that influences attitudes towards disability: traditional support systems that do exist are most often based on these beliefs; as Peter Coleridge states “Islam itself brings a sense of social responsibility, evident in such things as ‘Zakat’ and ‘Ushr’<sup>44</sup>, both forms of donating charity to those who have less (...) Helping deprived people, which included disabled people, is a religious (and therefore charitable) duty through which the giver accrues credit for the hereafter.”<sup>45</sup>The charity model comes into play for other causes of disability, specifically those that are not clearly identified. On the receiving end of the charity are the persons with disability who feel a sense of shame for ‘extending a begging hand’<sup>46</sup>. This model is even more valid for the mentally disabled, as NDSA results showed that a huge majority of persons with physical and sensorial disabilities as well as the non-disabled stated that the “dewana” or mentally disabled should not have the same rights as other categories.

**Figure 50: Distribution of Persons with Disability Above 14 Years Old According to Participation in Ceremonies by Gender, Area of Living**



As a result, participation in ceremonies is a reflection of social visibility and acceptance. This is true in all ethnic groups. Overall, people largely take part in a variety of ceremonies. Yet, a certain proportion of people with disability aged 15 and more do not: 20.0% of men and 32.7% of women. These figures are similar in urban and rural areas: there is no additional exclusion or stigma in villages.

Both persons with disability and non-disabled gave responses<sup>47</sup> in similar proportion about the major ceremonies they attended in 2005. The major ceremonies that people quote are those linked to the major events of life: marriage (32.5%) especially, followed by death ceremonies (13.2%) and birth ceremonies (3.1%).

They also participate in various religious ceremonies that are major events in the lives of all Afghans. Among them Eid, which marks the end of Ramazan, constitutes the most important celebration in the country. It lasts for 3 days starting with the breaking of fast before the morning prayer. For the occasion, people who can afford it, buy new clothes. Families meet for important meals and festivities. Eid Qurban, the ceremony that takes place in preparation of the pilgrimage to Mecca is also an important occasion in the social life of Afghans. People who intend to make the Hajj or pilgrimage, as well as hajjis who went in the past, sacrifice animals and organise banquets.

*Participation in ceremonies is a reflection of social visibility and acceptance. This is true in all ethnic groups. Overall, people largely take part in a variety of ceremonies. Yet, a certain proportion of people with disability aged 15 and more do not*

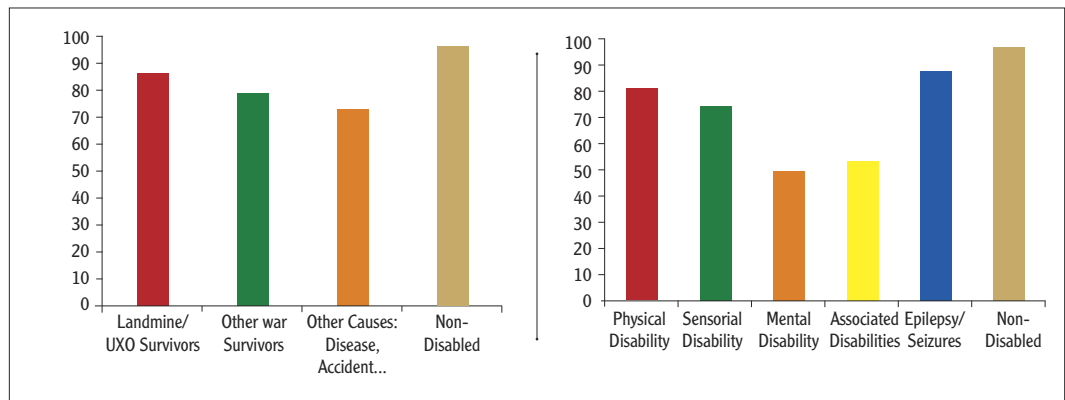
<sup>44</sup> Zakat and Ushr are religiously defined donations for those who are considered to be less fortunate. According to the definitions given in the report “Afghan perceptions of disability”, Zakat is obligation, religious tax when you own house, property, and can be given in money or food. Ushr is 10% of lalmi harvest (rainfed), and 20% of abi harvest (irrigation) that is for the less fortunate.

<sup>45</sup> COLERIDGE P. (1998), op. cit.

<sup>46</sup> Interview of a person with disability during the pre-test of the NDSA questionnaire.

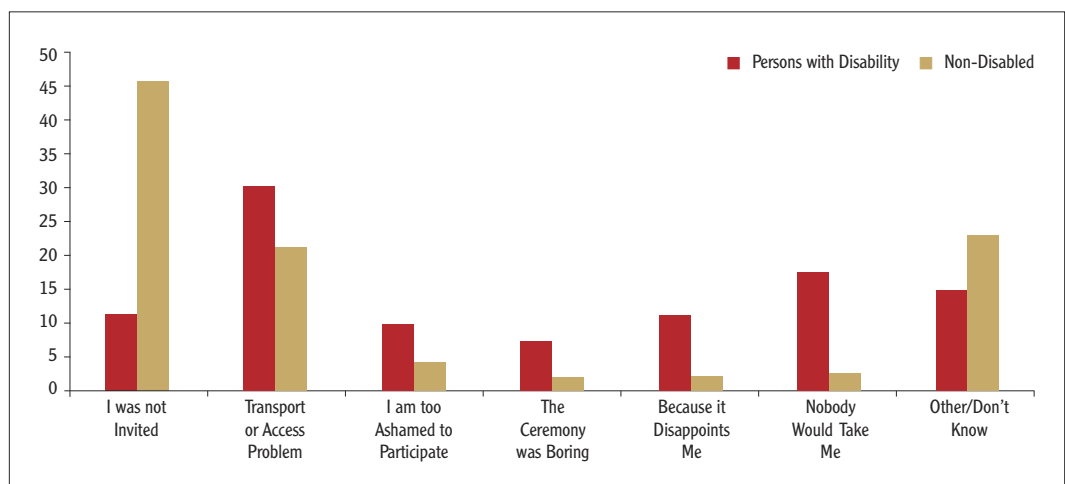
<sup>47</sup> Interviewees could quote up to 3 ceremonies in their answer.

**Figure 51: Distribution of Persons with Disability Above 14 Years Old According to Participation in Ceremonies by Types and Causes of Disability**



Such events are very important and reinforce the sense of belonging to the community. Therefore, for people who are kept away from them, this represents segregation from family and community life. 27% persons disabled due to accident, disease or mistreatment are in this situation.

**Figure 52: Distribution of Persons with Disability and Non-Disabled According to Reasons of Non-Participation in Ceremonies**

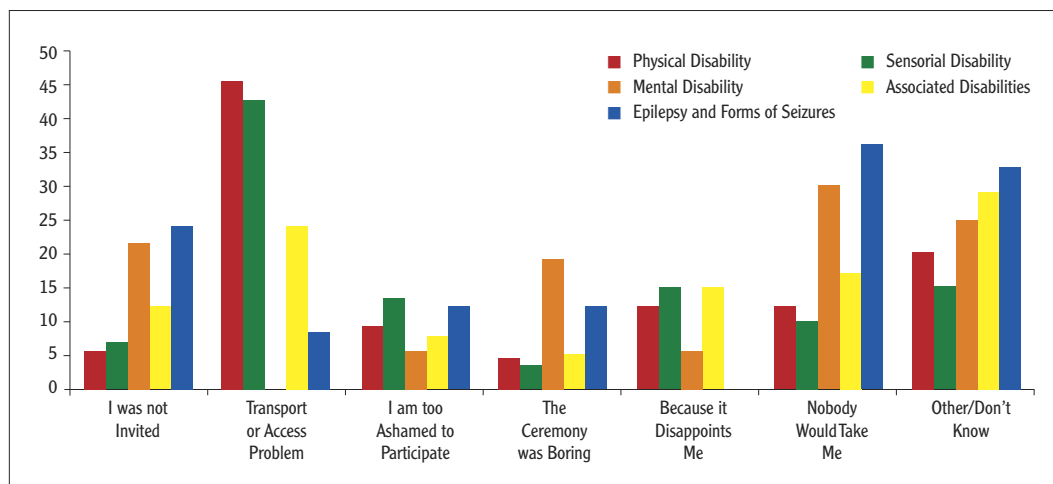


Are all persons with disability on an equal stand regarding participation in social life? Figure 51 shows that persons with physical disability or epilepsy or other forms of seizure do participate in higher proportion than other forms of disability. Persons with mental forms of disability or associated disabilities participate in a lesser proportion in these social gatherings. They are often victim of stigmatization and rejection.

A small minority of non-disabled persons (3.2% of men and 4.6% of women) who do not participate in ceremonies declare that it was due mainly to absence of invitation or of means of transportation as shown in Figure 52.

Non-disabled persons not participating in social gatherings state the fact that they were not invited. However, this needs to be interpreted with caution since this usually means that there was no celebration. It can also signify that there are also marginalised groups in the community due to different reasons. Similarly for this group, transport problems usually signify the venue was far and that the entire family could not go.

**Figure 53: Distribution of Persons with Disability According to Reasons of Non-Participation in Ceremonies by Types of Disability**



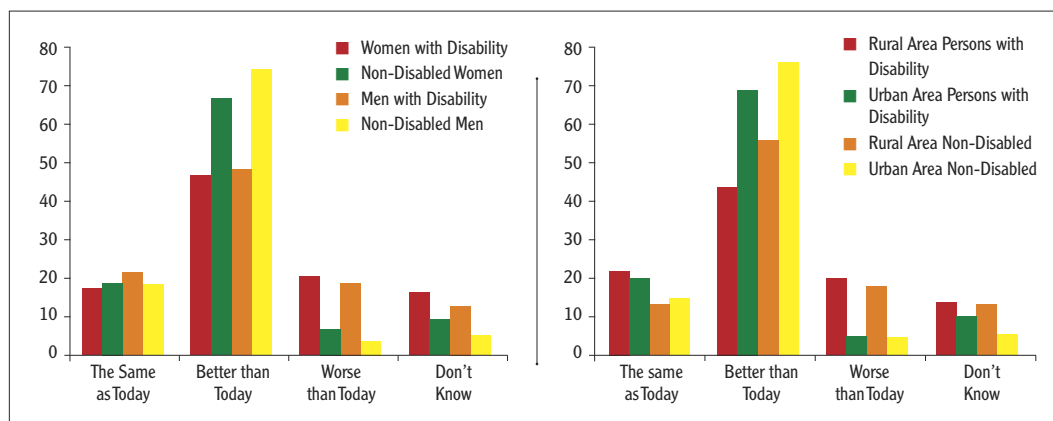
Persons with disability face a larger variety of problems. The 11.2% that stated that they were not invited can be considered together with 17.4% who state that nobody would take them. Many answers show there is a certain effect of non-acceptance that leads to a feeling of shame in being with others: 9.5% declared openly that they were ashamed to participate, another 10.7% that it disappoints them and 7.0% that they got bored. In other words, they did not feel at ease with other people. Not being fully accepted, 55.8% of them feel shunned in one way or another.

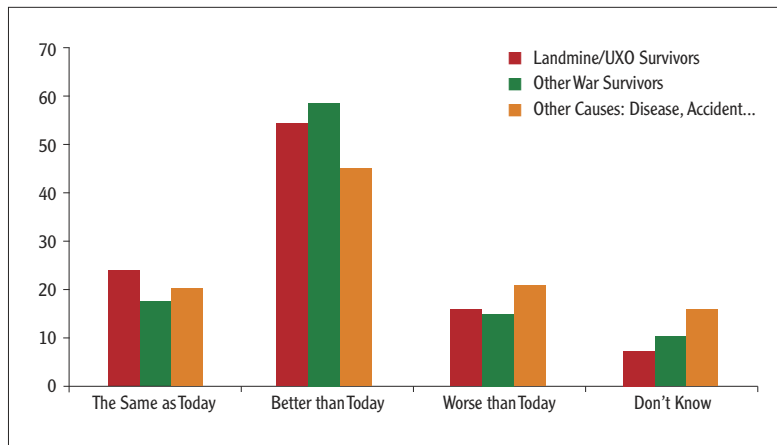
Looking at the breakdown by types of disability as shown in Figure 53, the main problem for persons with physical difficulties is access to or at the venue (45.5%). Transport is also stated as the main problem for 42.6% of persons with sensorial disability. Persons with mental disability state that either they were not invited or nobody would take them to the celebration. These latter reasons are also stated by persons having epilepsy or seizures.

It is difficult to completely grasp what participating in these ceremonies clearly implies in terms of acceptance and inclusion. On one hand participating in these celebrations is related to having certain visibility within the family and the community. However, apart from problems of physical access and transport (which is shared by the non-disabled as well) there is a certain level of 'exclusion' of the mentally disabled. Nevertheless, whatever is the reason for it, the absence from major ceremonies that are inherent to Afghan social life is a sign of ostracism and isolation.

*Whatever is the reason for it, the absence from major ceremonies that are inherent to Afghan social life is a sign of ostracism and isolation*

**Figure 54: Distribution of Persons with Disability and Non-Disabled According to Perception of the Future by Sex, Areas of Living and Causes of Disability**





## Fear of the Future or Scope for Optimism?

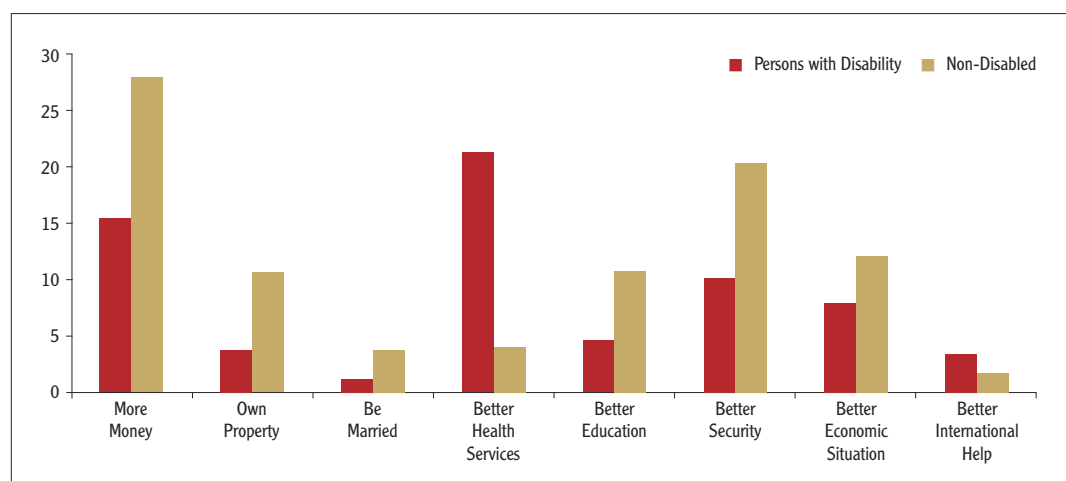
All together, Afghans were, in 2005, rather optimistic about the future: a massive majority (69.9%) expects their personal situation to improve in the next 5 years. However, only 47.5% of persons with disability believe their situation will improve in the next 5 years, while 70.7% non-disabled persons believe so. This reveals that persons with disability have a general feeling of distrust, or at least of scepticism, in the capacity of the Afghan society to give them an equal place.

*The feeling of a better future is more widespread among war survivors than among other persons with disability*

Women are globally more pessimistic than men when it comes to considering ones situation in the near future: 73.7% of non-disabled men believe their situation will get better, compared to 66.5% of non-disabled women. Persons with disability are overall less optimistic than the non-disabled. Moreover, only 46.6% of women with disability believe their situation will improve and 20.2% of women with disability believe their situation will be worse, while 16.0% don't make any forecast and 17.2% think nothing will change for them. This feeling that the situation will not improve is far more widespread in rural areas than urban areas. Yet, there is no significant difference by region. Only the people in the Western region seem to be more optimistic than the others. 78% believe that their situation will improve.

Again, the feeling of a better future is more widespread among war survivors than among other persons with disability. 54.2% landmine survivors and 57.5% other war survivors are optimistic for the future, whereas 45.3% persons with disability due to another causes (accident, disease, etc.) think their situation will get better one way or another. The rest of this last category is almost equally split between the idea of status quo (19.3%), the belief that the situation will deteriorate (20.3%) or the absence of any forecast for the future (15.3%). There are a series of reasons for this. The most important one is the social valorisation of the

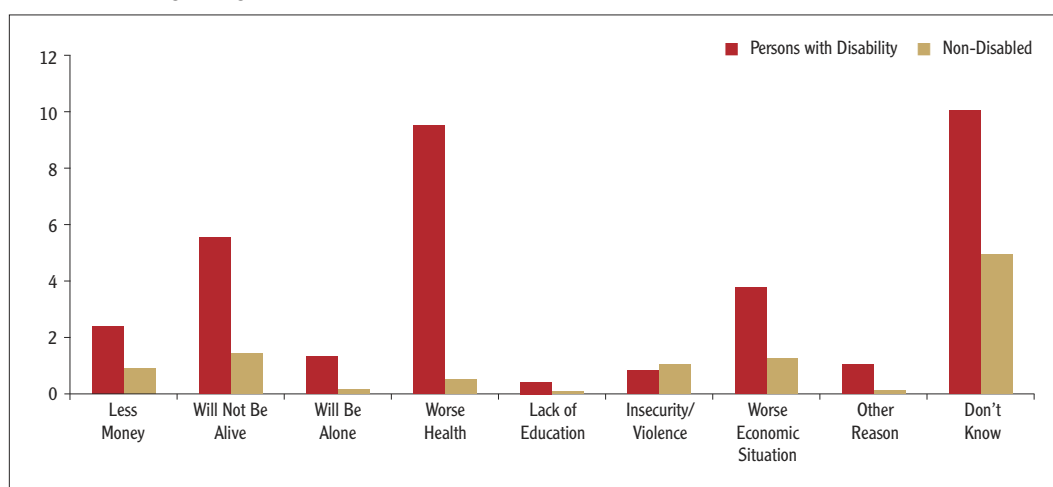
**Figure 55: Distribution of Persons with Disability and Non-Disabled According to Reasons Why they Believe the Future Looks Better**



war survivors, who as a consequence, feel socially well integrated and have high visibility. Benefiting from a number of organisations and DPOs working with the physically disabled, they have a general feeling of having prospects both for work and social life. These perspectives are not easily shared by the other categories: as a result 10.0% of those disabled by other causes declare they believe their situation will be worse. Among people who think the situation will be worse, many cannot give a reason for their pessimism.

In 2005, when asked, a majority of non-disabled Afghans believed that their situation would improve over the next five years for a range of reasons mainly related to the general situation, more than their private life. 46.1% of them believe they will have more money (28.0%), benefit from better security (20.1%), better economic situation (12.0%), better education system (10.4%), and health services (only 3.6% though). In addition, a certain proportion also believed that their own situation would improve because they would earn more money (27.8%), or because they will own property (10.4%). Acquiring a piece of land to build a house and/or do farming is essential for youngsters to settle down. In 2005, very few were pessimistic, believing that violence would resume, for instance (1.1%). 4.8% did not know what the situation would be like. Maybe the same question today would obtain different answers...

**Figure 56: Distribution of Persons with Disability and Non-Disabled According to Reasons Why they Believe the Future Looks Worse**



*Inclusion is a major factor to look at when formulating recommendations for stakeholders active in the disability field. Today, Afghanistan does not yet have disability public policies that express commitments to equalise opportunities for persons with disability*

However, persons with disability did show optimism regarding the improvement of health services, a major factor of well being in the future.

For persons with disability, the perception of the future was more pessimistic in 2005. In addition, the reasons given were very different. One major preoccupation of 15.0% of the persons with disability was that their health situation would worsen or even that they would not be alive anymore. They also are more often concerned about the economic situation (6.2%). 10.0% of persons with disability also have no idea of what their future might be. Persons with disability still have difficulty in Afghanistan in picturing themselves in the future.

# Conclusion

Inclusion is a major factor to look at when formulating recommendations for stakeholders active in the disability field. Today, Afghanistan does not yet have disability public policies that express commitments to equalise opportunities for persons with disability. Furthermore, while in the process of being established, these policies must be defined by the persons with disability themselves. The NDSA project in general, and this document particularly, is a tool for organisations of persons with disability, to help them find their way against social and environmental barriers and their place in Afghan society. The project adopts a capability approach towards disability by focusing on what individuals value doing or being in a given environment. It also highlights the social, economic and environmental barriers to equality that persons with disability undergo in the Afghan society.

## Remove Barriers

The economic environment has a major impact on opportunities in terms of employment and autonomy of persons with disability. Generally barriers are related directly to the type of disability the individual has. Working, whether in an administration, a company, in the fields or outside the compound, is a significant issue for persons with disability. This can ultimately affect their ability to gain an income, or to produce food and engage in income generating activities. Inaccessibility is due to several constraints: impairment as well as poverty and physical inaccessibility. Other types of barriers are linked to attitudes and prejudice.

## Changing Social Attitudes and Beliefs Regarding Disability

In Afghanistan, a problem arises from the fact that disability is not perceived in the same way everywhere, and varies according to gender differences, traditional or ethnic attitudes and religious motives. Therefore, persons with disability may be more or less vulnerable in daily life and may not be subjected in the same way to poverty. In fact, they do not constitute a homogeneous group, but various sub-groups facing different needs and opportunities.

## Gender Concerns

The fact that in many areas of social and economic life, women are systematically in a worse situation than men is of great concern. The NDSA analysis clearly shows that women with disability are poorer, cannot access school, are in worse health conditions, do not participate to the labour market and, as a result of stigmatization, are excluded from social participation. Better access for women and girls with disability to health services and to schools can be ensured by increasing the number of women staff.

## Access to Employment and Income: Changing Perception

When asked, the first thing persons with disability seek is a job to earn their living. While progress is being made towards employment for persons with disability, many barriers remain, especially for women with disabilities and persons living in remote rural areas. The labour market, dominated by the agricultural sector, provides few opportunities for the most impaired, and especially for women if they are disabled. Yet, the practice of a paid activity is a clincher for social recognition, thus self-esteem and independence. Nevertheless, average income of persons with disability is lower and the level of unemployment is higher than that for non-disabled. Even if the level of employment for persons with physical or sensorial disability (mainly men) and for war survivors is as high as for non-disabled persons, the level of income remains lower for the former. An active employment policy based, among other measures, on a general obligation of employment of a certain percentage of persons with disability, both in public and private sectors, is a first step towards inclusion in the labour market.

## Access to Public Services: Health and Education

Many of the causes of impairments and injuries are preventable by increasing the level and quality of antenatal care, improving women's health education, improving immunisation, eliminating malnutrition and

*While progress is being made towards employment for persons with disability, many barriers remain, especially for women with disabilities and persons living in remote rural areas*



promoting awareness regarding a balanced diet and other daily practices to improve health. In brief, priority focus should be placed on prevention rather than cure, using a multidisciplinary approach that includes local leaders and other communication tools such as radio broadcast.

Persons with disability are currently spending more for their health and using the health facilities more than non-disabled. Nevertheless, they face more constraints and difficulties in benefiting from a better health. Ensuring access to health services is a priority. A major issue is to address barriers to access public health services such as distance to health facilities and cost. For people with reduced mobility, assistive devices – standardised, well-made, well-fitting, using local materials whenever possible and repairable locally – should be made available countrywide. Availability of generic drugs at the lowest possible price is also a challenge. The development of vaccination programmes is another challenge. In order to follow-up with the inclusion of persons with disability in the health system, and particularly at the level of the BPHS, they should be tracked through the MoPH information management systems.

The current efforts of different decision makers to send children to school are not reaching persons with disability equally. The proportion of non-disabled children accessing public schools is almost two times higher than the proportion of children with disability. Another major challenge is access to school for girls, and especially girls with disability. The current deterioration of the security situation might become a step backward in the access to school for girls in parts of the country. An important way to strongly support inclusive education is to make schools accessible to children with disability and change legislation in order to include children with all types of disability, including the most severely disabled, in schools for the compulsory education period. Responsibility for the education of children with disability will be placed upon the MoE along with a coordinating body to be created. A major issue is awareness – to convince teachers and both families of children with disability and parents of other children of the relevance of inclusive education. Because integration of children with disability into the general educational system requires planning by all parties concerned, the coordinating body will ensure effective coordination work of all stakeholders, from conception of the law to training of teachers, awareness of community and designing of buildings.

### **Empowerment: Decisions Taken by Persons with Disability**

Persons with disability have not yet succeeded in having their voices heard, except for war survivors who are the only persons with disability enjoying real prestige in Afghan society due to their status as former Mujahidin. The capability approach applied to disability offers a perspective of empowering all persons with disability by providing a framework aiming at equal entitlements for persons with disability and non-disabled persons. The well-being and subsequent freedom of persons with disability depends on their capacity to express their needs and benefit from opportunities offered by a welcoming and inclusive environment. Public policies must ensure their capacity to fully participate in social life.

### **Mainstreaming: Inclusion and Accountability?**

Gathering of knowledge on livelihood, beliefs, needs and expectations of persons with disability is a way of fuelling a national disability strategy based on such principles as empowerment and mainstreaming. This view, which has been put forward by a number of disabled persons' organisations, tends to look at the barriers that exist within the social context and that prevent a person from achieving the same level of functioning as that of a non-disabled person. In this perspective it is society that needs to be redesigned in order to take into account the disabled persons' needs. Mainstreaming persons with Disability is a progressive way of reshaping society in order to better include them.

### **Coordination of Action and Actors: Towards the Institution of a Coordinating Body?**

The participants in the First National Landmine Victim Assistance Workshop held in Kabul between 6th and 8th August 2006 at the Ministry of Foreign Affairs enthusiastically advocate the creation of an independent coordinating body in charge of disability issues in Afghanistan with a strong representation of organisations

*Gathering of knowledge on livelihood, beliefs, needs and expectations of persons with disability is a way of fuelling a national disability strategy based on such principles as empowerment and mainstreaming*

of persons with disability<sup>48</sup>. This body could take up the task of programming, managing and coordinating the disability policy in a field where actions are currently planned by different ministries and carried out in isolation by various local governmental bodies or implementing agencies, especially INGOs.

This coordinating body could be in charge of promoting and protecting the full range of the rights of persons with disability, including their right to accessibility, education, employment, rehabilitation and health, and welfare support. Persons with disability should be fully represented in this body as they have a central role to play in the formulation of the national disability strategy in different issues that affect their lives directly.

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<sup>48</sup> See “Addressing the rights and needs of mine survivors and other persons with disabilities: The Government of the Islamic Republic of Afghanistan’s objectives and plan of action for the period 2006-2009”, Kabul, August 2006.

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The National Disability Survey in Afghanistan was carried out in 2005. It is the first such study that covered the entire territory. Based on the International Classification of Functioning, Disability and Health of the World Health Organization, and the Capabilities Approach of Amartya Sen, the NDSA aims to provide insights into the living conditions, needs and hopes of Afghans with disability and their families. A brief overview of the results is presented here in the Executive Summary Report. This document is a first glimpse into the lives of this vulnerable group and provides a comprehensive understanding that is vital in order to define policies and programmes.

