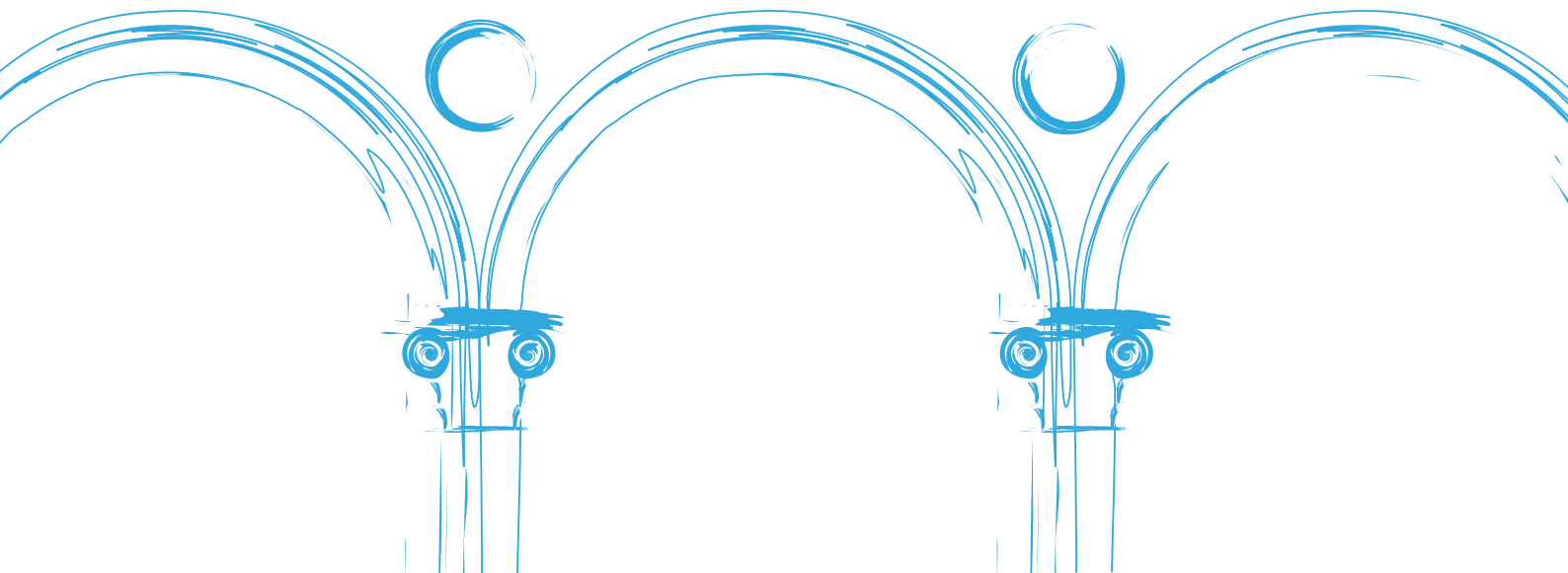


# Barriers and Facilitators to Providing Assistive Technologies to Children with Disabilities in Afghanistan

Golnaz Whittaker and Gavin Wood

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Correspondence should be addressed to:

### **UNICEF Office of Research – Innocenti**

Via degli Alfani 58

50121 Florence, Italy

Tel: (+39) 055 20330

Fax: (+39) 055 2033 220

[florence@unicef.org](mailto:florence@unicef.org)

[www.unicef-irc.org](http://www.unicef-irc.org)

@UNICEFInnocenti

[facebook.com/UnicefInnocenti](https://facebook.com/UnicefInnocenti)

## BARRIERS AND FACILITATORS TO PROVIDING ASSISTIVE TECHNOLOGIES TO CHILDREN WITH DISABILITIES IN AFGHANISTAN

Golnaz Whittaker, UNICEF Office of Research – Innocenti

Gavin Wood, UNICEF Office of Research – Innocenti

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## Overview

Due to the impacts of the ongoing conflict, Afghanistan's child population is at high risk of being born with or acquiring a primary or secondary disability. According to a recent estimate, up to 17 per cent of Afghanistan's children live with some form of disability. Assistive technologies (AT) – the systems, services and products that enhance the functioning of people with impairments – are likely to be required by a large proportion of children with disabilities in Afghanistan. Afghanistan has signed and ratified the United Nations Convention on the Rights of Persons with Disabilities (CRPD), which includes a commitment to provide AT equitably to all who need it. However, little action has been taken to meet this commitment, and there continues to be a vast gap between the need for AT and its provision. This work presents the landscape of AT provision, the barriers and facilitators to provision, and provides recommendations to begin to close the gap.

## Approach

A review was conducted of the global literature to understand what is known about the nature and scale of AT provision in humanitarian settings, and best practice in AT delivery. The review identified several knowledge gaps, with a key question being whether the paucity of academic literature reflected a deficiency in provision. We aimed to fill the evidence gaps by conducting an in-depth examination of field-level provision in two protracted crises – Afghanistan and South Sudan (see separate report) – which offer contrasting examples of humanitarian response. We conducted a literature review describing AT provision in Afghanistan and identified the relevant organizations and key informants to participate in the research.

The global literature provided good evidence regarding the barriers to AT *access* for children with disabilities, therefore, a key objective of the case study was to focus instead on explaining the (low) levels of AT *provision* in Afghanistan. As such, the focus of this research was on providers rather than recipients of AT services. Informants included programme managers, implementation staff, policy leads, health, education and child protection advisers, advocacy leads and other experts with a role in the programme provision for children with disabilities. Semi-structured interviews were conducted to build on the evidence in the literature, and to understand the factors affecting AT provision in Afghanistan. Due to the ongoing COVID-19 pandemic, interviews were conducted remotely. Pandemic restrictions also limited the scope of research. For example, implementers' projects could not be visited, but may have also led to more informants being accessible to researchers, due to the relative ease of online meetings in comparison to arranging in-person discussions.

## Findings

The majority of AT provision in Afghanistan is led by a minority of non-government organizations (NGOs). Most of that provision is of mobility devices through rehabilitation

centres, which are almost all located in provincial capitals. Their location makes them difficult to access by the majority-rural population. There were few examples of free-at-point-of-use AT for visual, hearing, communicative or cognitive impairments. As a result, it is likely that most children with such impairments do not have access to the devices they need. Key barriers to access include high levels of stigma against children with disabilities, constraining demand, and the paucity of provision, particularly for the populations who need it the most.

The lack of AT provision is driven by a variety of interrelated factors, for example, limited data on AT need, the failure of the government and humanitarian agencies to prioritize children with disabilities' needs, and low technical capacity by those responsible actors to instigate, maintain and expand quality AT services.

### Objectives

Organizations with a responsibility for the humanitarian response in Afghanistan – including the government, donors, multilateral agencies, NGOs and civil society – have a responsibility to coordinate AT provision for all children who need it. It will not be enough to scale up existing provision of devices. This research aims to engage all responsible actors to coordinate their activities, prioritizing the following actions:

- Make the needs of children with disabilities a priority of the humanitarian and development agenda, including but *going beyond* 'inclusion' to address the specific needs of children with disabilities;
- Map AT services, needs and gaps, both geographically and by impairments;
- Establish a monitoring mechanism and timeframe for meeting the CRPD commitments;
- Establish funding mechanisms to capacitate and scale up existing provision based on evidence, ensuring that provision reaches beyond provincial centres and is accompanied by the necessary long-term services and awareness-raising to tackle stigma.

**Audience:** Organizations with responsibility for the humanitarian response in Afghanistan – including the government, donors, multilateral agencies, NGOs and civil society.

## Summary of findings

- The most recent study on disability prevalence in Afghanistan estimated that almost 80 per cent of Afghan adults have some form of disability, of which 14 per cent were found to have a severe disability. The study found that within the child population over 17 per cent have some form of disability (5). Under 5 per cent of people used an assistive device. The same study found that 44 per cent of adults surveyed did not use assistive devices because they were not aware they existed. Among those who did not have assistive products, 66–72.7 per cent needed them.
- The single most wide-reaching free-of-charge AT provider in Afghanistan we found was the International Committee of the Red Cross (ICRC), which provided over 100,000 assistive devices in 2019 (111), and has the capacity to provide tailored devices for children. ICRC production is likely to represent the vast majority of national production of assistive devices for children and adolescents (and indeed adults) in Afghanistan. Such AT supply (and, by inference, demand) has grown since 2014, when ICRC reported distributing under 30,000 devices (112).
- The majority of known free-of-charge AT distributors, including ICRC, provided devices to assist physical rehabilitation in response to mobility impairments. As of November 2020, there were between 18 and 23 operational physical rehabilitation centres providing AT in Afghanistan: these were managed by ICRC, Humanity and Inclusion (HI), Swedish Committee for Afghanistan, several local NGOs and government. We found no evaluations related to the outcomes or impacts of any of these AT interventions.
- We found little AT service provision for other (non-mobility) impairments, such as sensory impairments. Respondents stated that some devices – e.g., hearing aids and eyeglasses – were increasingly available in markets (at least in some provincial capitals) and, in some cases, affordable. We found limited evidence on the source of these products or their cost, availability and take-up.
- Many organizations' guidance documents state that they take a 'twin track' approach – i.e., providing services to meet the specific needs of people with disabilities, and ensuring that people with disabilities are included in mainstream provision. However, we found little evidence of specific services for people with disabilities.
- There was strong agreement among respondents and the grey literature, that one of the key barriers to both AT provision and access in Afghanistan is distance between services and those with needs. Insecurity, poverty and poor infrastructure exacerbate difficulties related to both beneficiaries travelling to centres, and providers taking services to beneficiaries. Providers reported that this stymied their ability to extend much-needed provision to remote areas outside provincial centres.

- A further access barrier is the high level of disability-related stigma. Respondents shared reports from the field in which children with disabilities were abandoned, hidden or even chained in their homes. Service providers emphasised that any efforts to improve provision must include programming to tackle negative attitudes to disability.
- Barriers to provision and scale-up include lack of organizational expertise on how to manage large-scale AT distribution outside of agencies' specialised (geographic and thematic) provision areas, as well as lack of financing. Donors' lack of interest in disability issues was cited, as was donor fatigue with Afghanistan more generally. Donors' failure to either provide funding for AT, or to demand that government meet its CRPD commitments, was seen as a key driver of the gap between need and provision.
- Low government capacity to sustain services begun by NGOs was cited as a risk for organisations who might otherwise have had an interest in developing services to fill AT provision gaps. Respondents described centres being asset-stripped or mismanaged after handover to government. Respondents said that corruption and nepotism were systemic problems preventing handover. Donations distributed by government had 'disappeared' or been inequitably allocated to the public.
- Agencies described a key challenge to both coordination and provision of AT services: the government's involvement and leadership was crucial to sustainability, but the government had repeatedly failed to be an effective partner or leader in the sector.
- This case study provides recommendations based on our findings, covering operational approaches, policy and advocacy needs, and research needs.

## Case Study: Assistive technology access and provision for children and Adolescents with disabilities in Afghanistan

### Objectives of the case study

A literature review was conducted on the barriers and facilitators of AT provision in humanitarian settings globally.<sup>1</sup> The review found several gaps in the literature, including those related to:

- The nature and scale of AT provision in crises beyond the acute phase;
- Evidence of the comparative effectiveness of models of AT provision and coordination in crises;
- The impact of interventions with the objective of improving or scaling up AT access in a crisis;
- The rate of child and adolescent-specific AT needs;
- How to alleviate barriers to provision and access;
- The nature of coordination and provision in protracted crises, particularly camp settings and settings where international agencies have a large mandate and capacity.

This case study on AT explores the extent to which these gaps are understood in Afghanistan; the same case study approach was repeated in South Sudan and similarly in the State of Palestine and reported separately. In summary, this case study aims to:

- Describe what is known about the AT needs of children in Afghanistan;
- Map the AT providers and services available in Afghanistan;
- Understand the barriers and enablers of AT provision and access in Afghanistan.

### Methodology

#### **Rationale**

The objectives above required the research team to gain an understanding of the motives and perspectives of potential and actual providers of AT in humanitarian settings, and other humanitarian (and development) actors involved in the provision of services and goods for people with disabilities. Qualitative approaches can be an effective way of meeting these objectives, as they can offer explanatory tools to develop an in-depth view of an issue. The case study approach is a qualitative research methodology that can elicit evidence relevant to decision-making in the areas of both policy and professional practice. This approach involves examining a phenomenon in its context using multiple sources of data in order to build a holistic picture (1). Case studies are particularly useful for research questions concerned with the 'how' and 'why' of a phenomenon, where the context is central to the phenomenon being studied (2). These characteristics make the case study approach

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<sup>1</sup> Whittaker, G. and Wood, G., *The Provision of Assistive Technology to Children with Disabilities in Humanitarian Settings: A Review of the available evidence on the current state of provision, gaps in evidence, and barriers to and facilitators of better delivery*, UNICEF Office of Research – Innocenti, Florence, 2022.



appropriate for exploring barriers and enablers to AT provision for children in humanitarian contexts.

A key purpose of this case study was to test the findings of the global literature review and fill any knowledge gaps identified. There is relatively good evidence on the barriers to AT access, and on the disadvantages children face when they do not have access to AT, and so this was not a focus of the research in Afghanistan. The main enquiry was first to focus on whether the lack of academic evidence related to AT provision in humanitarian settings was reflective of an actual paucity of provision. Furthermore, if this was the case, to identify the factors leading to such low provision. The focus of this study was to gather evidence and views from staff working for agencies with a role in humanitarian coordination and implementation of services for people with disabilities, many of whom had disabilities themselves.

Key informant interviews are an affordable qualitative approach that draws on the knowledge of experts in a field, to gain an understanding of the motives and perspectives of actors involved in a phenomenon. They are a valuable tool in filling knowledge gaps regarding complex behaviours, and can bring to light issues which researchers have not previously considered (3). As they involve small sample sizes, key informant interviews may be limited in their ability to show the validity of findings (4). However, in this study we were trying to understand the very limited landscape of AT provision in Afghanistan, and the factors effecting the nature and small scale of provision. As a result, the small size of the sample was to some extent inherent to the issue being studied.

Further, we saw strong and consistent agreement between a range of respondents in different organizations regarding the main barriers to provision. The interviews both corroborated the academic literature findings, and helped identify new issues that were not emphasized or found in the literature prior. This supports confidence that this research both adds to the evidence base on the state of AT provision in Afghanistan, and supports the validity of the findings.

### **Grey literature review**

First, a literature search was undertaken to establish the documented evidence base. 186 items were found in the grey literature discussing disability and rehabilitation services in Afghanistan since 2010. Items of grey literature included web pages, government reports, conference proceedings, theses, research reports and press releases. A minority of these (approximately 50) made mention of assistive devices (some refer to assistive devices generally, and some to specific services such as mobility products, braille or prosthetics and orthotics services). Two reviewers independently chose which articles should be excluded

The team used the grey literature to provide an overview of the evidence base on:

- The status of disability
- The policy and legal landscape of assistive technology provision
- AT provision at national and local levels
- The role of NGOs and multilaterals in the provision of AT services and products
- Coordination mechanisms for AT provision

This evidence was recorded in this report and strengthened through the key informant interviews.

### **Sample**

Based on the grey literature, all organizations were identified that currently play a role in the provision of assistive technologies in Afghanistan, including advocacy organizations. The aim was to ensure representation from government, donors, multilateral organizations, international and local NGOs and civil society. The primary focus of the research was to understand barriers to provision (as opposed to barriers to access), as this is a key gap in the literature. As a result, key informants were chosen from organizations that had a current or potential role in AT provision, to understand their experiences and views.

Two techniques were used for identifying the interview sample: key informant sampling (where those targeted would be knowledgeable based on the findings of the grey literature review), and snowball sampling (asking key informants for recommendations for who else they considered experts). In conducting key informant sampling, three contact attempts were made, and if there was no response after that point, the team did not pursue the organization or individual further.

### **Methodological caveats**

The research team aimed to follow best-practice guidelines for conducting interview-based research (3). However, challenges were anticipated related to collecting data through informant interviews. These included challenges related to seeking a representative sample of informants. There was a risk a biased sample could be collected by using researchers' own contact points in organizations where information was not found in the public domain. As such, the team sought to make formal contact with organizations wherever possible, even where there was access to researchers' contacts. The team worked with organizations' public contact points to identify who would be experts in the research topic, by accompanying introductory emails with a written briefing on research objectives. The desire to speak with a range of experts in each organization was articulated if possible.

There was a risk that organizations might have an incentive to put us in contact with their staff in public-facing communications roles, as opposed to experts on the topic, in order to share a more formal or sanitized perspective on their work. In seeking key informants in

consultation with contact points, we explicitly communicated that we sought to maximize the representation of all staff, considering the representation of:

- local staff
- international staff
- staff at different levels of seniority
- staff in different roles (e.g., policy, implementation, HQ-based, field-based)

The use of snowball sampling helped to mitigate against the risk of only identifying contact points in larger or more well-resourced organizations we were already aware of, or that had a better online presence. While the population size of our sample was unknown, there was agreement within both the grey literature and among interviewed informants that the number of organizations with a role in AT was small, and there was therefore a high level of confidence we could contact and cover the majority of organizations with such a role. However, smaller, local organizations that were unknown to our participants (who were mostly based in provincial capitals) may have been unwittingly excluded.

Semi-structured interviews were conducted, using the flow chart in Annex C, ensuring consistency and some comparability of themes across interviews, while allowing follow up on issues and concepts introduced by respondents. Each interview took between 1–2.5 hours, depending on interviewee availability. Response bias was a risk, particularly as respondents knew that UNICEF funded the research. Respondents might exaggerate the levels of need, or their organizational capacity or achievements, in pursuit of future funding or partnership. However, broad agreement was noted across different types of organizational responses on the types and levels of need, including from international organizations that were unlikely to be interested to seek funding from UNICEF. This increased confidence in the findings.

Written and oral briefings were also provided on the research purpose, to ensure clarity that it was not related to any potential or actual funding. Where possible, multiple representatives were interviewed from each organization, and where possible interviews conducted separately to allow respondents to express opinions freely without being consciously or unconsciously influenced by colleagues.

The methodological approach was also influenced by the ongoing COVID-19 pandemic. National travel restrictions prevented researchers from country-based fieldwork, which would have allowed for additional data-gathering (such as in-person visits to sites of provision), or more independent approaches to identifying key informants (e.g., based on first-hand observations of implementation). However, there may have been advantages to these restrictions. For example, many agencies have adapted to remote – and therefore more accessible – online working approaches following pandemic restrictions. This may have allowed for more interviews with a greater number of informants thanks to the efficiencies realized through remote working.

Informed consent was sought from participants, by providing them with a written pre-briefing on the research aims and how the information they shared would be used, and by then seeking signed consent forms from all participants. This consent form assured participants their responses would be anonymized in the write-up, and that data would be stored securely. Interviews were recorded through typed notes, which were sent to each participant after the interview to seek their assurance that the record accurately reflected the conversation, and to allow them to make any corrections they deemed necessary.

Thirty individuals were interviewed working for 17 organizations, all based in Afghanistan:

- 3 working in multilateral agencies
- 11 working in international NGOs
- 9 working in local NGOs and civil society organizations
- 1 working for government

Responses were also received from three donor organizations that declined to be interviewed. One limitation of our study is related to the difficulty of seeking participation from donor organizations that have lower incentives for participation (or in fact may be disincentivized to participate), due to higher pressures to reflect headquarters' policies in responses. One observation was that there was very little evidence of bilateral donor-funded AT provision or specialist provision of services for people with disabilities, and this may have led to those organizations thinking they had no expertise to share in this research.

A summary is provided of our sources of data (*see Annex A*), to demonstrate points of agreement between the grey literature and interviews, and to identify where interviews provided additional information not found in the literature.

## **Context**

Afghanistan is in a protracted crisis. It has experienced near-constant conflict and terrorism over the past three decades, which has negatively affected the health of the population and the quality and reach of infrastructure, including health and education infrastructure. In recent years Afghanistan has seen an increase in internally displaced persons and returnee refugees, which has placed a huge burden on its already overstretched infrastructure. Children in Afghanistan are often exposed to war and violence that can lead to disabling injuries. Afghanistan also has high rates of consanguinity, malnutrition and birth defects which can lead to disability (5).

Consequently, disability prevalence is likely to be particularly high, and to have grown over the past two decades of conflict. The 2005 survey of disability by Humanity and Inclusion found that 2.7 per cent of Afghans lived with a severe disability. Using a different methodology, a 2019 model disability survey conducted by the Asia Foundation estimated that, 13.9 per cent of adults lived with a severe disability. The same study found that 17.3

per cent of children experience some form of disability. Rates of disability are likely to differ based on geography, as the ongoing conflict has a major impact on numbers of persons with disabilities. The south of Afghanistan is likely to have the highest numbers of people with disabilities, due in part to higher levels of conflict and less access to health services (6).

After the defeat of the Taliban in 2001, Afghanistan saw a surge of funding from international donors, including to health and social welfare services<sup>2</sup>. Health services in Afghanistan are overseen by the basic package of health services (BPHS) programme (designed in 2003 and ongoing today), which includes maternal and new-born health, child health and immunization, nutrition services, the treatment of communicable diseases and mental health, disability and rehabilitation (7)(8). The BPHS is delivered primarily through NGOs, who are each responsible for the delivery of the BPHS in one or more of Afghanistan's 31 provinces (8). The BPHS has been responsible for major gains in key health indicators since 2003 (9). The BPHS is funded through the Afghanistan Reconstruction Trust Fund (ARTF), a multi-donor trust fund funding development programming and capacitating the government.

Similarly, education infrastructure has increased enormously since 2001. In 2001, only 1 million children in Afghanistan were in education, but by 2015, government estimates suggested between 6 and 11 million children were attending school (10). This has been achieved in part through the expansion of community-based education and the promotion of girls' enrolment (11). Despite these successes, children with disabilities continue to be far more likely than other children to be excluded from education. The Ministry of Education has estimated that 75 per cent of children with disabilities have never accessed education (10).

### **Sources of data: AT needs and disability prevalence**

No AT needs assessments have been conducted in Afghanistan. A Humanity and Inclusion report states that in 2017, 0.16 per cent of the population received prosthetic and orthotic services (12). This is compared with estimates that 0.5 per cent of the population are in need of an assistive device of some kind (this is the estimate used by Humanity and Inclusion and the government, based on World Health Organization (WHO) guidance).

Disability prevalence data has been gathered through the health and education management information systems, though this data is considered unreliable, even by the government (13). Sources of disability prevalence data outside of government systems (i.e., conducted by independent agencies) are detailed below.

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<sup>2</sup> this report was written prior to US withdrawal

One regularly updated source of disability data is the **Afghanistan Living Conditions Assessment (ALCS)**, which is conducted approximately every two years and uses a household survey. The ALCS does not use the Washington Group questions on child functioning and disability, and no evidence was found that the Washington Group questions have been used in a survey in Afghanistan. The 2016/17 ALCS estimates that 3 per cent of the population has a disability. Approximately 1 per cent of children aged 5–14 are estimated to have a disability, rising to 1.6 per cent for children aged 15–19. Boys between 15–19 are estimated to be twice as likely as girls to have a disability (14).

The **National Disability Survey in Afghanistan (NDSA)** was conducted in 2005, commissioned by the government and conducted by Humanity and Inclusion to meet the need for reliable data on disability (15). The NDSA used a combination of the international classification of functioning (ICF) and capability approaches, in order to identify not only impairments, but functional limitations to participation (15)(16). The NDSA estimated that 2.7 per cent of the population had a severe disability, and 4.7 per cent had some form of disability (15). The study estimated that of the child population living with disability, half were born with disabilities, rather than acquiring their disability in childhood (15). Children who acquired disability after birth or from a known cause were 3.9 times more likely to attend school than children who were born with a disability (16)(17)(15). The NDSA has been used to inform the National Strategy for Disability and Rehabilitation (2016-2020), which reproduces NDSA estimates of different disability prevalence as follows:

|                      |     |                                |     |
|----------------------|-----|--------------------------------|-----|
| Physical disability  | 37% | Multiple physical disabilities | 46% |
|                      |     | Paralyses                      | 29% |
|                      |     | Physical deformity             | 12% |
|                      |     | Lack of one limb               | 12% |
| Sensorial disability | 26% | Visual impairment              | 32% |
|                      |     | Hearing impairment             | 25% |
|                      |     | Speech impairment              | 23% |
|                      |     | Speech and hearing impairment  | 15% |

The NDSA found that girls with disabilities were 2.7 times less likely to attend school than boys with disabilities (15). The dual barrier of being female and having a disability seriously affects school access and learning outcomes, which do not seem to have been significantly alleviated by the rapid expansion of girls' education provision facilitated by community-based education. Children with physical disabilities were 3.2 times more likely to attend school than children with mental and cognitive disabilities (15)(16)(17). At outcome level, the differences were even more marked – children with physical disabilities were 9.6 times more likely to be literate than children with mental disabilities (15). 75 per cent of those with disabilities lived in 'rural and poor semi-urban areas' (5).

In 2019 the Asia Foundation published its **Model Disability Survey of Afghanistan (MDSA)** (5)(18). The study found that only 21.1 per cent of the adult population had no disabilities: 24.6 per cent experienced mild disability, 40.4 per cent moderate and 13.9 per cent severe disability. Prevalence rates for children were found to be lower, with 82.7 per cent of the child population having no disability: 6.6 per cent had a mild, 7.1 per cent a moderate and 3.5 per cent a severe disability (5). The most commonly cited limitations experienced by children were related to using transport, taking part in the environment for peer and community engagement, and taking part in school (5). The MDSA found that the use of assistive devices was at under 5 per cent of the population for all devices. The most expressed need was for eyeglasses and walking support. The most used devices were eyeglasses (4.1 per cent), followed by canes and walking sticks (3.2 per cent) and chairs for self-care (1 per cent). Of those who used assistive devices, the majority experienced no difficulties with use. The most commonly reported difficulties were related to products being uncomfortable and the wrong size.

The **2016 Global Burden of Disease study** found that in Afghanistan, lower respiratory infections were the first cause of disability adjusted life years (DALY) for children under 5, followed by congenital birth defects. For children between the ages of 5 and 14, the leading cause of years lost to disability was conflict and terrorism (19).

A **2019 Afghanistan Independent Human Rights Commission** survey-based report on 979 children and adults with disabilities across 28 Afghan provinces found that physical disabilities were most common, followed by visual, hearing and mental disabilities (5). Causes of impairment were identified as likely to include war (with half the victims of explosive weapons in Afghanistan being children), heart disease, respiratory infection, road injuries, birth defects as well as poor health services and malnutrition (5).

Save the Children has completed a technical **assessment of functional impairments**, using Washington Group questions. The outcomes of this survey are not yet available (20).

### **Provision by international humanitarian and development donors**

No donors in this research reported any current AT programming or AT components within their funding portfolios, outside of provision under the BHPS and essential package of hospital services (EPHS), which are funded through the ARTF. The ARTF was established in 2002 as a World Bank-managed mechanism through which donors could rebuild and fund Afghanistan's institutions. ARTF provides funding to multiple sectors and programmes, including BPHS and EPHS. The three major donors to the EPHS and BPHS are the World Bank, European Union (EU), and the United States Agency for International Development (USAID) (21). EPHS and BPHS are delivered under the oversight of the Ministry of Public Health. In the majority of provinces, the BPHS and EPHS are delivered via NGOs that bid for

contracts to provide the relevant package of services in a geographic location for a set period of time.

There was reference to historical donor-funded funding for rehabilitation projects focused on AT provision. One such example is the USAID-funded Afghan civilian assistance III programme (2015-2018), which was implemented by United Nations Mine Action Service (UNMAS) and supported the establishment of mobile and static rehabilitation centres (22). This programme provided prostheses, among other AT support, targeted at victims of conflict and mines. A further example is the towards improved quality rehabilitation services in Afghanistan programme (TIQRA), an EU-funded project aimed at training rehabilitation professionals in Afghanistan, which ended in 2019 (23).

Physical rehabilitation was included in the 2018-2021 humanitarian response plan (HRP) for the first time. This provision is targeted at 1.5 million people in 80 conflict-affected districts, where health cluster partners aimed to establish a range of trauma, rehabilitation and psychosocial services. 15 per cent of the target group are children and adolescents. 45 per cent of this target group is likely to need aftercare that is unlikely to be available in the context (12).

#### **AT under the BPHS and EPHS**

The gap between BPHS and EPHS plans and reality is likely to be substantial, as acknowledged by the national strategy for disability and rehabilitation (2016-2020). According to this strategy, and the latest available BPHS policy (2010), all rehabilitation services under the governance of the Ministry of Public Health (MOPH) are delivered through the resources of the BPHS and EPHS programmes, under the responsibility of the disability and rehabilitation department (DRD). These programmes include physical rehabilitation and mental health services. Under DRD plans and policies, community health workers - trained under the BPHS - are responsible for identifying and referring people with disabilities. In reality, most families identify disabilities themselves (24).

According to the BPHS policy, assistive devices (specifically, crutches and walking aids) are to be provided at district hospitals. Other devices, such as 'wheelchairs and assistive devices for children with cerebral palsy are to be referred to 'orthopaedic workshops centres' (referred to in this report as physical rehabilitation centres, as they are more commonly known) (12). The guidelines on physical rehabilitation services through the BPHS include minimum standards for rehabilitation centres, and state there is a need to increase the production of mobility devices. However, no details are provided on the number or types of devices needed, or how the MOPH plans to increase production (25). Further, the national strategy for disability and rehabilitation states that hospital-based provision of assistive technologies should be part of the EPHS, but that implementation of these services is poor due to donors' lack of clarity about the 'place of physical rehabilitation in the EPHS' (24).



Despite the inclusion of disability-focused services under the BPHS, one study suggests that people with disabilities have not experienced an improvement in the availability of health care between 2005 and 2013. This is in the context of rapid gains in healthcare coverage for other demographic groups in the same period. The study also states that “the claims of improved quality of care in Afghanistan... do not seem to apply to remote, hard to reach and potentially dangerous areas ...” (26).

Informant interviews suggested that AT provision as part of BPHS was unlikely to be widespread or effective. This supports the government’s own assessment of the quality of rehabilitation provision in the national disability strategy. No respondents discussed AT provision under BPHS when asked to relate their understanding of what AT provision is available in Afghanistan. One respondent reported that BPHS had many operational challenges, and that children with disabilities were unlikely to receive specialized support through its provision package (20).

### **Provision by government**

#### Government policy and commitments

- The Government of the Islamic Republic of Afghanistan (GIROA) signed and ratified the CRPD (including the optional protocol) in 2012. The Afghanistan Independent Human Rights Commission (AIHRC) is monitoring the implementation of the CRPD, however Afghanistan has not yet reported against CRPD commitments.
- The 2004 Constitution of Afghanistan (Article 53) states that financial aid will be available for people with disabilities (27). Despite the provisions of the constitution and the CRPD, government documents make clear that only children who acquire a disability because of war or terrorism are eligible for government-provided disability benefits. Children who are born with a disability or acquire a disability for any other reason must access mainstream services, or local specialized services if they are available.
- GIROA has signed the Proclamation on the Full Participation and Equality of People with Disabilities in the Asia Pacific Region (18).
- GIROA has signed several conventions to end the use of mines and munitions, for example the Convention on Cluster Munitions in 2011 (13). The research found reference to draft plan that would guarantee people with disabilities access to physical rehabilitation services (28). However, no current national strategies for disability were available online. Implementing partners shared a draft national strategy for disability and rehabilitation (2016-2020), which is also referred to in the planning documents of NGOs with a prominent role in AT provision (12).

The following government ministries are responsible for aspects of AT provision, according to national strategies and policies:

- The MOPH is responsible for national physical rehabilitation services through the DRD, which is being restructured under the new name of the national disability rehabilitation programme (DRP) (12):
  - o MOPH sets the specifications for the staffing, services and equipment included in both the BPHS and EPHS (discussed above, under donor-funded provision) (7). Supervision of BPHS and EPHS is through both central and provincial offices of MOPH (12). The MOPH has responsibility for overseeing quality standards for NGOs providing AT provision services, which in reality constitutes the majority of AT provision. A raft of service quality standards were published by the MOPH in 2013, referring to standards for physiotherapy, prosthetic and orthotic physical rehabilitation services, and rehabilitation training (12).
  - o In 2018, the disability and rehabilitation budget was 0.12% of the total health budget (12).
- The Ministry of Martyrs and Disabled Affairs (MMDA) is responsible for ensuring Afghanistan's compliance with the requirements of the CRPD (24). MMDA is also responsible for managing a system for registering people with disabilities to access disability benefits.

### **Government-led AT provision**

In the absence of a report against CRPD commitments, the only government record of its provision for people with disabilities can be found in the 2017 report on the Convention on Cluster Munitions (13). The report provides the following information on AT provision and child disability data, according to the contributions of different ministries:

- Ministry of Education (MOE): An inclusive education department to be established within the MOE in 2018 to collect data on children with disabilities in the education system. Up until the end of 2017, the education management information system reported 3,808 children with disabilities in education, however this number is reported to be unreliable (13).
- Ministry of Labour and Social Affairs (MOLSA): Registers war-wounded people and provides them with a disability pension. As a result of Afghan Civilian Assistance Program (ACAP III) implemented by United Nations Mine Action Service (UNMAS) under the oversight of MOLSA, physical rehabilitation services were delivered to 2,774 beneficiaries in 2017. However, the majority of disability-specific services are provided by NGOs (13).
- MOPH: As of 2017, 21 orthopaedic centres were established in 16 provinces (13).

A USAID-funded report on the implementation of the CRPD found that only 27 per cent of respondents to a survey of official employees and people with disabilities were aware of any

organizations that distributed assistive devices. Of these, only 3 per cent cited government provision, and 6 per cent cited benevolent individuals, with the remainder of reported provision being from NGOs, charitable organizations and civil society. This supports the finding that there is likely very little government-led provision of assistive devices and services to children with disabilities (29).

Public hospitals can provide assistive devices free of charge, however the research found no evidence of how or whether devices are systematically procured for the public health system. There was reference to NGOs providing devices to public hospitals managed by the MOPH, but it is unclear whether these are donated or part of a systematic procurement plan, and is not referenced in the 2016-2020 national health strategy (12).

### **Provision by Civil Society**

Disability Rights Watch Afghanistan (DRWA) is a network of organizations of people with disabilities (OPDs). Some small funding has been provided by the United Kingdom's (UK) Foreign, Commonwealth and Development Office (FCDO, previously the Department for International Development or DFID) to establish this network, through the British and Irish Agencies Afghanistan Group (BAAG).

In 2018, a local advocacy organization called Community Centre for the Disabled (CCD) and BAAG conducted a provincial mapping to understand the number of Afghan OPDs that exist, where they are located and the types of services they offer (30). The mapping identified 84 OPDs in Afghanistan and 96 per cent of the OPD representatives were male. The majority of OPDs identified were based in city centres, registered with a government ministry and received donor support from either a local or international donor. The mapping found that the most common activity for OPDs was food distribution on behalf of the World Food Programme. Most other activities were related to inclusion of people with disabilities in community life. However, over half of surveyed OPDs also supported improved mobility through repairing prosthetics and wheelchairs. Seventeen OPDs were focused on visual or hearing impairments, and four OPDs were focused on speech impairments. The majority of the OPDs supported under 500 beneficiaries. Only 18 per cent supported more than 500 beneficiaries, suggesting that small-scale assistance was the norm.

The majority of OPDs identified in the CCD/BAAG mapping exercise did not primarily advocate on AT provision, but rather prioritized issues such as the distribution of shelter to people with disabilities, and called for disability benefits to be paid. OPDs also prioritized advocacy for children with disabilities to receive education services. Some advocacy for children has been successful: for example, one OPD successfully lobbied to establish a school for girls with visual impairments, and others secured discounts for university tuition for adolescents with disabilities.

Through interviews, the research found that civil society organizations also aimed to change the government's position on only providing financial support to those with war-related injuries:

“Disability rights organizations believe that it is clearly discrimination in the light of CRPD. The government has to consider all persons with disabilities equally, whatever the causes are in getting services and support” (31).

### **Provision by NGOs and multilateral agencies**

The grey literature suggests that those who have access to AT receive it largely through national and international NGOs (18)(28)(13)(12). The majority of interview respondents reported that government provision of AT was minimal<sup>3</sup>. This view is supported by the national strategy for disability and rehabilitation, which states that there is limited provision of AT through national systems, and that most physical rehabilitation centres (PRCs) are managed by NGOs. The majority of physiotherapists are employed by NGOs and international organizations (22).

Almost all free-at-point-of-service AT provision that was described by interviews and identified through the literature is of mobility-related devices through PRCs. PRCs primarily make, supply and fit prosthetic and orthotic devices, as well as – in some cases – other mobility devices, such as crutches or walking frames. Many PRCs, even if managed by NGOs are connected with regional and provincial hospitals run under MOPH oversight through the EPHS (25). It is the stated intention of the MOPH that NGO-managed rehabilitation services will, over time, be integrated into the public health system (25).

There was disagreement between informants and official documentation regarding the number of PRCs that were operational. According to the physical rehabilitation strategic plan, 23 PRCs were operational in 16 provinces in 2018, of which three were run by MOPH (12). A GIRoA representative said that as of 2020, there were 23 centres providing AT, but that five of these were managed by the MOPH, with the remaining 18 operated by NGOs. The Afghan National Society for Prosthetics and Orthotics (ANSOP) recently reported that there are 22 PRCs operational, of which only two are managed by the MOPH (*see Annex B*). This discrepancy in numbers could be caused by a number of different factors, including different definitions of what constitutes a PRC (for example, the government may include centres that provide physiotherapy only, and which do not manufacture or provide devices). Further, some PRCs may be not be consistently open, and therefore there may be disagreement regarding whether they should be counted as operational. One key informant

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<sup>3</sup> Other respondents stated they were not aware of provision outside of NGO provision, with the exception of the few government-led PRCs that also draw on NGO support. The number of government-led PRCs was disputed, as discussed elsewhere.

reported that some government-led centres were not operational, despite government claims, and that those that were operational were of poor quality.

Available details of programming that includes children with disabilities are provided in the summary table below (see Table 1). Interview respondents were not aware of any *child-focused* assistive device provision interventions that were currently live, although there was evidence of child-focused organizations partnering with AT provision organizations to distribute devices (32). There was also no evidence of the effectiveness of AT interventions in Afghanistan for children specifically – this is linked to the absence of evaluations of AT interventions more broadly.

**Table 1: Programmes in Afghanistan that include AT provision**

| Implementer   | Summary  |
|---|--|
| International Committee of the Red Cross (ICRC)                                     | ICRC runs seven rehabilitation centres in Kabul, Herat, Balkh, Nangarhar, Kapisa, Badakhshan and Helmand. ICRC trains and employs specialist personnel in rehabilitation centres. Almost all of the 750 staff are former patients (39).                                |
| Swedish Committee for Afghanistan (SCA)   | Provision of mobility and assistive devices to over 52,700 people in four regions (Balkh, Nangarhar, Takhar and Ghazni) through physical rehabilitation centres and community-based approaches.  |
| Save the Children (StC)   | No AT-specific programming, however StC's child protection programming includes a cash intervention component which can be used to buy assistive devices.  |
| Humanity and Inclusion (HI)   | Development of curriculum and training course for physiotherapists, prosthetic and orthotic technicians. Community-based psychosocial support and rehabilitation. HI also runs a physical rehabilitation centre in Kandahar.   |
| International Assistance Mission (IAM)  | Runs an eyecare programme called Noor in hospitals in three provinces. Also run mental-health programme, and programmes for ADHD and developmental delay. Not all services are free-of-charge.   |
| Kabul Orthopaedic Organisation (KOO)  | Manages a physical rehabilitation centre in Kabul. Also provides CBR through mobile teams (12).  |
| Disability Afghanistan Organisation (DAO)   | Manages 2 physical rehabilitation centres, in Kunar and Zabul. Also provides CBR through mobile teams (12).  |
| Rehabilitation Centre of Youth (RCY)  | Manages a physical rehabilitation centre in Faryab.  |
| Basic Package of Health Services (BPHS) and Essential Package of Hospital Services: | Rehabilitation/AT component of BPHS includes provision of crutches and walking aids at community health centres and district hospitals. Rehabilitation professionals at hospitals measure people with disabilities for wheelchairs and assistive products for children |

|   |   |
|---|---|
| multiple implementers, funded by the Afghanistan Reconstruction Trust Fund (ARTF) | with cerebral palsy. Patients will be referred to orthopaedic workshops for prostheses, orthoses and other assistive devices. The MOPH manages one recently renovated PRC in Kabul, and one PRC in Khost. |
|---|---|

There was evidence that three new PRCs have recently been opened:

- Health Disability and Development Organization (HDDO) in Baghlan
- In Bamyan), which may be partially operational, and whose activities are not fully known. They also report that Amputee Bicyclists for Rehabilitation and Recreation (AABRAR) runs a PRC in Farah, which is not always open, and have activities in Paktya.

Evidence of small numbers of specialist schools for children with disabilities was found. Organizations managing these schools had partnerships with the providers in the table above to seek and distribute assistive devices (32). Such specialist provision includes, for example, Norwegian Afghanistan Committee’s support for the Deaf School in Kabul, and its collaboration with the Afghan National Association of the Deaf to develop an Afghan sign language dictionary (40).

Community-based rehabilitation (CBR) has been provided by a number of national and international NGOs in Afghanistan, including SCA, HI and SERVE Afghanistan (12). The most extensive provider of CBR services inclusive of assistive devices is likely to be SCA, which as of 2018 was operating CBR in 12 out of 34 provinces (12). No evidence related to the number of assistive devices distributed through CBR was found to date.

Providers of physical rehabilitation services reported there were good systems in place for the provision of mobility devices, and that procurement challenges were minimal:

“We have a component factory. It is where we make wheelchairs and the parts for prosthetics and orthotics, etc., to be assembled and adapted for each disabled person (everything we deliver is custom made). We provide... [to international and local NGOS] and others on demand, free of charge, with these components. They tell us we need this or that or training. When we introduce new components, we ask them to send technicians to be trained. We have a school, and a new course is starting on 15th December.” (International NGO staff member)

NGOs and multilateral agencies also have a role in developing guidance for the expansion and improvement of AT provision. For example, the United Nations Educational, Scientific and Cultural Organization (UNESCO) has published a toolkit and associated materials to improve inclusion of children with disabilities in Afghanistan. UNICEF is currently working

closely with GIRoA to develop a comprehensive social protection policy that covers all people with disabilities who need support (33).

The majority of agencies (including UNICEF) reported they had no programmes specifically targeted at providing AT to children (or adults) with disabilities, and that their approach continued to be one of mainstreaming and improving inclusion (33). The 'twin track' approach advocated in many guidance documents – in which agencies deliver both specialist provision and mainstreaming – is therefore not in evidence. One example referenced the use of ramps in programming when, in the absence of wheelchairs and tricycles, such investments cannot in fact result in improved access (34) (35)(36). One respondent acknowledged that agencies' emphasis on mainstreaming led to a risk that "it [disability provision] can be mainstreamed into oblivion if no specific intention is put forward to do something" (33). One respondent proposed that donors were more supportive of 'soft' disability-inclusive programming (i.e., awareness raising, advocacy), as opposed to the technical task of delivering specialized services such as AT:

"We cannot go beyond 'soft' nature of projects for people with disabilities, because it is technical and because we cannot find donors willing to fund [it]. (37)

NGOs that provide AT tend to specialize in one or a small number of products for one type of impairment and are rarely able to operate at scale. This corroborates findings from the literature on the paucity of child and disability specific programming (38)(18)(6).

#### Provision by the private sector

A 2018 HI report finds that some assistive devices are available in local markets, including wheelchairs, walking frames, crutches and pressure-relieving cushions (12). However, this report does not identify whether such products are equally available in different parts of the country, or their affordability.

ANSOP reports there are four PRCs in Kabul which are commercial workshops led by private organizations. These sites manufacture orthopaedic devices. The commercial organizations are Irtifa, Nawid Sehat, Aryana and Parsa.

Key informants agreed there was some availability of assistive devices in the market in Kabul, though informants emphasized the private provision of glasses and hearing aids over other types of devices. No further evidence was found on costs, availability or levels of take-up:

"Glasses are available in the market. Hearing aids are available, but quality is not great. Of course, it comes at a cost, so not everyone is able to access." (39)

“We sell glasses, we do not give them away for free. We will not let people not receive health services. We will cover glasses if they are really poor. Glasses at [redacted] cost about 1.5 dollars to 3 dollars. So, most people could afford that. We do not buy fancy ones... [we] bring frames in from India and Pakistan. But adding prescription and tailoring happens in Afghanistan.” (41)

“Hearing aids are now available in the markets - I have seen this in private shops. In terms of variety and new technology we do not have that available in the market – [e.g.] software, audio learning materials”. (31)

### **Gaps in AT provision**

According to HI estimates, only a third of the population have had their prosthetic and orthotic needs met. This implies a large gap between needs and provision, given that mobility devices such as prosthetics and orthotics are likely to be more available than devices for other types of impairments, such as visual, hearing or cognitive impairments (12).

The MOPH finds that only 21 out of 34 provinces have any physical rehabilitation services, and that these services are often seriously understaffed (22). The MOPH confirms that demand outstrips supply (22). Interview respondents similarly estimated high levels of unmet need, supporting the findings of the grey literature and recent surveys such as the 2019 MDSA. All respondents agreed there was a lack of accessible AT to meet the needs of people with disabilities in Afghanistan. One respondent said:

“Despite everything we do, I would say less than 50 per cent of those in need are assisted. But that is an estimate, it is very difficult to know. No one really knows.” (39)

Several respondents said that there was a particular lack of free-of-charge AT provision targeted at non-mobility impairments:

“Mobility devices for physical disability [are] more available than other technical areas like visual impairment, hearing impairment, mental impairments. Those things are very rare. It is sensitive and needs medical expertise as well. That is why it is hard for civil society organizations to execute such projects. That is a huge gap for us.” (37)

“The assistance that is really hard to find here are therapies - speech therapy, sign language, braille, computers for people with visual and hearing impairments.”(32)



## Barriers

### Barriers to access

The travel distance to health care facilities, out-of-pocket costs, insecure environments and poor perceptions of health services are key barriers to access by the most vulnerable (42). Stigma against people with disabilities and lack of knowledge about available services are further barriers found both in the literature and from interviews.

**Poverty:** The majority of healthcare spending in Afghanistan is through individual/household income. 73.6 per cent of all health spending represents out-of-pocket spending from private sources. Only 5.6 per cent of total healthcare expenditure in Afghanistan is from the government, and donor funding represents 20.8 per cent of health expenditure (9). As a result, costs associated with accessing AT are most likely to fall to households who cannot afford it. Several respondents cited poverty as a reason for children with disabilities not accessing AT services:

“Poverty. You eat only if you work. So, to stop work and take your family 100km away to a service? You cannot.” (39)

**Distance** compounded by poor transport infrastructure and **insecurity** is a particular barrier to both access and provision. Rehabilitation services are rarely available at community levels and most people with disabilities need to access the nearest district or provincial hospital to access the specialized provision they need (12). A HI survey on financial access to rehabilitation services (2016) found that 90 per cent of the Afghan population lives more than 100km from a rehabilitation centre. Twenty provinces have no prosthetics or orthotics provision. PRCs are the main mechanism for provision of assistive devices, and not every province has a rehabilitation centre (22). Interview respondents agreed:

“Some months ago, I was in Faizabad. I asked a gentleman ‘how far is your home from here?’ The man said ‘8’. I said ‘8 hours?’ He said ‘no, 8 days’. And it is true, there are places where you must walk for days. If you are a paralysed person, how can you travel?” (39)

“Security is a big problem. In the past we could easily move around the country and go to remote areas. Ideally it would be good to open 5, 6, 7 centres more in remote areas...in the past, we could go and have outreach programmes - we used to call them field trips...But for security reasons we cannot do that anymore. It is too dangerous. At least half of Afghanistan is not under the control of the government. There is active fighting going on.” (39)

“One of the barriers for AT is that streets and paths are in such poor repair. If you are in a chair, there are few places you can go. You do not have paved roads.” (41)

**Stigma:** Traditional attitudes to disability serve to exclude children with disabilities from accessing the services they need, including AT. One NGO worker said:

“There is huge stigmatization of children with disabilities...they are seen as embarrassing for families...there is no justice for people who sustained disabilities from the conflict. Nobody cares, the conflict has been going on for so long” (20)

Children who are born with an impairment or who have an impairment with an unknown cause are called ‘mayub’, which is a derogatory term (43)(42). The term ‘dewana’ – meaning having a learning disability – is also derogatory. These forms of impairment have a negative association and sometimes considered to be the will of God or the result of negative supernatural forces. As a result, children who are born with disabilities may be hidden or regarded as ‘shameful’ (42). By contrast, people who are ‘malul’ – impaired due to a known cause, such as landmine victims – experience less stigma, and may even be viewed positively if they are war-wounded (43)(42). Almost all interview respondents agreed that stigma was high and resulted in children being prevented from accessing AT:

“We were astonished to find an example in a province ... [a female teenager] was being hidden by her parents in her home, so that no one knew there was a girl with a disability in her home, as her siblings and cousins would suffer if people knew there was disability in the family.” (37)

“In some extreme cases, some parents will kill their child with disability [...] People see physical disability as the only legitimate form of disability... Children with physical disabilities are often excluded from education. They may be turned away from services, especially if [they are an] IDP [internally displaced persons] or returnee...Children with other forms of disabilities, e.g. learning disabilities - you will find their parents are more prone to neglect [them].” (44)

“In severe situations you have violence against people with disabilities, including torture, people being chained up. Navigating that is key.” (44)

“It’s very distressing, but it’s the case that with a lot of children with disabilities, when they start showing signs of their impairment, they are discarded by their families...” (45)

There is some limited evidence that children with disabilities now experience less psychosocial distress in 2013 compared with 2005, and this may be related to communications to reduce stigma (42). Different groups experience different levels and forms of stigma – for example, older men with intellectual or psychosocial disabilities did

not experience negative attitudes from the community but women with psychosocial disabilities experienced significant barriers to inclusion.

**Limited family and individual awareness of rights and services:** In Afghanistan, as elsewhere, ‘access’ is not only a matter of availability of services and professionals: family has an important role in facilitating access (46). Mothers may play a particularly important part in supporting and encouraging access to health services for children with disability, as they may be the decision-maker on health issues (46).

The importance of awareness is supported by the recent MDSA survey, which found that approximately half of Afghans surveyed did not use an assistive device because they did not know such a device existed (18). Similarly, a Counterpart International survey found that, of 64 surveyed people with disabilities, 89 per cent did not know their rights or any laws related to people with disabilities (29). Providers that were part of the research were aware of this barrier:

“Physio[therapy] and [assistive] devices are partly unknown in much of Afghanistan. In Kabul they know what we are doing. But if you go to the countryside, people do not know what this is, they will not send patients. Afghanistan is drug and surgery oriented. So, there is ignorance, prejudice. Even doctors might not know what physiotherapy is. Ignorance, prejudice, distances and security are big problems. Every province should have a rehab centre, so people do not have to travel on roads for hours and hours” (39)

The same respondent pointed out that even widely available mobility devices were poorly accessed due to low awareness on the part of healthcare providers:

“In Kabul, if someone does not use a prosthesis, it is because he does not want it, because the opportunities to access are huge...If you go to orthotics that is a different story...The number in need of orthoses is much bigger. If you lose a leg, you go to hospital, and a nurse or doctor tells you to go to ICRC and get a leg. If you are a child or baby with a disability or a deformity, they will not necessarily go to a doctor, and if they do, the doctor will not necessarily refer them to orthotic services.” (39)

Barriers to provision

**Limited support from government agencies and low government capacity.** In a CCD/BAAG survey, this was reported by OPDs to be the greatest barrier to people with disabilities accessing the services they had a right to. Government either failed to implement the law or failed to support OPDs’ work. In some cases, OPDs reported outright hostility by the government. One OPD based in Bamyán reported a shop providing products for people with disabilities was destroyed by the municipality (30).

A USAID funded research project (29) aimed to analyse the barriers to government implementation of the CRPD in Afghanistan. It surveyed officials who were involved in CRPD implementation in multiple ministries, including the Ministry of Labour, Social Affairs, Martyrs and Disabled (MOLSAMD)<sup>4</sup>, MOPH, MOE, and other members of parliament. The project also surveyed civil society groups and NGOs. The survey concluded that within government, key issues were: lack of government interest in implementation; lack of awareness of the CRPD; lack of management, planning and coordination; and weak monitoring and evaluation systems (29). 77 per cent of respondents were not aware of the CRPD at all, even though they had a role in its implementation (29).

Interview respondents reiterated the findings of the literature. All respondents (including a government official) stated that the government had limited capacity. One NGO reported that local and national government are “not implementing the laws”; and another that “nobody respects and accepts the existing laws” (30). Several respondents said the policy environment appeared to be conducive to provision, but that this did not result in action:

“There is disagreement in government about who should receive provision. It is very unclear who is and is not eligible for assistance. At policy level there are a good number of laws, but the government did not come up with a specific plan of action to progress the CRPD or international laws into action. Local organizations are pushing government to put the law into practice.” (31)

The grey literature review found at least one report from government and NGOs agreeing that the national government does not currently have the capacity to manage necessary rehabilitation services, and is not expected to have the capacity for some time (22). This is despite the professed intention in the national strategic disability plan for the MOPH to manage these services. Several interview respondents agreed that the government did not have the capacity to take over services and centres once they had been established, and that corruption resulted in inappropriate staffing of previously working systems. One respondent told us that one attempt at handover of a physiotherapy centre to government had resulted in the centre being asset stripped and closed.

“We handed over physiotherapy centre to the government and it was asset stripped and closed for two years ... [NGOs] train psychosocial experts [for the BPHS programme] and then [after three years when providers change] the new provider fires everyone and puts their own person in place. This is because of nepotism.” (41)

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<sup>4</sup> MOLSAMD is now split into the Ministry of Labour and Social Affairs (MOLSA) and the Ministry of Martyrs and Disabled Affairs (MOMDA).

**Limited personnel:** Afghanistan has experienced ‘brain drain’ as trained health professionals left Afghanistan between 1979 and 2001. There are only six skilled healthcare workers per 10,000 people. Most are in the cities, which leaves rural areas (where the majority of the Afghan population lives), seriously underserved (9)(47). The cultural restrictions on women working may also have negatively affected the staffing, reach and quality of healthcare, including rehabilitation (43). Rehabilitation personnel, including prosthetists, orthotists and physiotherapists are limited – as an example, in 2018 HI reported that 981 physiotherapy provisions were vacant (48). There are three prosthetic and orthotics training centres in Afghanistan: in Kabul, Takhar and Herat, all of which are managed by NGOs. General psychology and counselling psychology courses are available at Kabul University, Mazar-e-Sharif University, Bamyan University and Herat University.

“Therapists are available, they do exist, but it is a small community.” (32)

“Donors are not keen on investing in Afghan education [e.g., in rehabilitation services]. Because Afghans go away and study and never return.” (41)

“We do not have enough personnel, though we have very well-trained personnel” (49)

**Limited funding available to local and international NGOs:** The BAAG survey reported that 42 per cent of local OPDs had no income and no success in fundraising. Of the OPDs with an income, a quarter cited the source as local donations from business people, and a quarter from government ministries or local government. Half reported receiving funding from an NGO: the most commonly cited source of funding was the Swedish Committee for Afghanistan and the World Food Programme (30). Staff were interviewed from local NGOs who confirmed these findings:

“We do need more financial support and more opportunities to support grassroots and local Afghan NGOs’ work. [Redacted name of NGO] is really struggling to survive...it would be an awful thing if they don’t survive, because they cover gaps that [other AT providers] can’t. We need support for these organizations, [and] we need big international NGOs to make it part of their agendas and provide resources.” (32)

“Due to lack of budget, we cannot expand our target areas. We are still working in same areas as 15 years ago. Many children want to be in our programme, and we must reject them as we do not have funds.” (50)

However, staff working for international NGOs operating at larger scale also cited funding as a barrier. For example, the establishment of PRCs is extremely costly, driven by the high

costs of equipment, raw materials and trained staff needed to operate manufacturing workshops (12).

“If you want to run ... a programme like ours, the costs are huge. We use local manpower and cheap tech to keep costs down, but we are still talking millions every year.” (39)

In the context of limited resources, organizations strictly prioritized their provision and reported an inability to expand. Organizations with existing mobility-focused provision pointed out that there was so much need that expanding their provision to new devices (e.g., hearing aids and glasses) would critically exceed their limited resources. Respondents also reported some availability of glasses and some low-technology products in the private market, which may further reduce agencies’ appetite for moving into the provision of these particular devices.

Informant interviews raised familiarity with disability issues and **staff knowledge and expertise** to develop disability-specific programming as a barrier to provision (33). This was cited by both NGO and multilateral staff. Availability of this knowledge was also limited in the market: one NGO adviser reported that it had not been possible to recruit a disability adviser either nationally or internationally, and so short-term technical consultants had been hired instead (20). They reported very few organizations with expertise and focus on children and disability in Afghanistan, which resulted in a “severe lack of understanding at [humanitarian] cluster level of what is required and therefore how to advocate for children with disabilities” (20). Furthermore, NGOs aim to work with national staff whose attitudes to children with disabilities may mirror that of the communities they aim to reach:

“National staff often identify them as children with problems, which is wrong” (20)

“Disability is so common in Afghanistan, that field staff don't see it [disability-specific services] as a need.” (44)

**Limited coordination:** There is currently no active OPD coordination mechanism within the humanitarian system in Afghanistan, though one was recently established (the DRWA). The historical lack of coordination has constrained OPDs’ ability to learn from successes and failures (30). Interviewees agreed that coordination of AT services was ad hoc and focused on coordination between organizations already providing AT to share resources, as opposed to working to strategically identify and fill gaps in AT provision nationally. Respondents also cited low capacity to coordinate on disability-related provision as a key barrier:

“[There is an] effort in government to coordinate from MOLSA. Disability issues are rarely discussed, however. ... There are not smart, specific targets around change.” (44)

“It is not just necessary to have more funds, but alongside funds, we need good planning - that is important. Most organizations in Afghanistan have enough funds but do not have a good plan. For example, they do not know what the goal is or how to access professionals or devices that we need.” (50)

**Limited data** on the number of people with disabilities and their specific needs has previously been suggested as a reason for the global lack of programming and policies to improve provision of services for people with disabilities in low- and middle-income countries. There is also a lack of evidence on best practice in conducting AT needs assessments. Informant interviews agreed that in Afghanistan, agency portfolios fail to include AT provision in part due to a lack of data.

Agencies’ own monitoring and reporting systems also contribute to a continued lack of data: for example, one respondent said that their own systems do not disaggregate the number of people with disabilities reached through their programming, so even the effectiveness of mainstreaming strategies are unclear (33).

**Donor failure to prioritize disability issues:** Several respondents discussed low donor interest in funding disability programming. NGOs and civil society perceived that donors and multilaterals failed to exert concerted pressure within the humanitarian and development system for response to the needs of people with disabilities:

“We need disability to be on the agenda. There's a lot more that these [donor and multilateral] organizations need to be doing. We need existing organizations like the UN and the World Bank to make disability a priority. To provide some funding for it. To play more of a role. To put it on their agenda.” (32)

“I have never had donors raise disability issues. Donors are generally interested on gender, conflict sensitivity, age. Sometimes around minority inclusion.” (44)

While respondents did not speculate on the reasons for the perceived low prioritization of disability, one did speculate that there was low appetite for expansion of AT programming to remote and insecure areas due to insecurity:

“... donors ... will not give money because they fear getting sued if our staff are hurt or killed” (41)

Respondents reported that this lack of donor pressure also affected the extent to which national health systems – largely funded by international donors – are concerned with the provision of services for people with disabilities:

“And there is low donor interest. P&O [prosthetics and orthotics] is yet to be included [in the] MOPH system. The Health Management and Information System (HMIS) does not yet reflect disability and rehabilitation due to lack of specific indicators, which makes it difficult to monitor the level of access to health and rehabilitation services of persons with disabilities among the general population today”(51)

### **Effects of the COVID-19 pandemic**

The literature and interview respondents reported the following effects of the COVID-19 pandemic:

- An increase in violence against people with disabilities, particularly women and girls with disabilities (52)
- Difficulties in receiving materials for the manufacture/provision of assistive devices, though this was not reported as being a major problem (39)
- Interruptions to programming, leading to delays in achieving targets (45)(51)
- An increase in out-of-school children: “[Due to COVID], what used to be 6 million children [in 2019] out of school is now 9 million” (20)
- More positively, for some the pandemic had revealed opportunities to deliver services to hard-to-reach populations remotely:
  - “COVID has been an amazing chance/opportunity – the whole of Afghanistan switched to telemedicine. If I had suggested online or phone counselling, government would have said impossible as infrastructure not there. Now I wonder if disability services could be provided remotely. No one could have predicted that” (41).
  - “We have activated an SMS system due to COVID-19, which prevented families bringing children to PRC. Proper follow-up SMS reminds families that they need to bring their child for treatment” (53).

### **Discussion**

#### **Corroborating the literature**

While many key informants corroborated many of the barriers identified in our literature reviews (both of the global academic literature and grey literature on Afghanistan), there was a difference in emphasis between the barriers identified in the literature, and the responses received from interviews with agency staff.

Some of the barriers discussed in the global literature, which we expected to be major barriers in the Afghan context, were not raised by interview respondents as concerns. For



example, respondents did not consider procurement to be a major challenge, and one individual working for a local NGO told us that materials for manufacture were available in Afghanistan (49). They stated that “it is possible to make low-cost wooden devices that are needed, as well as other devices in our workshops” (49). However, we found that very few organizations provided AT, other than mobility-related devices for which the supply chains are possibly well developed; and that organizations aiming to procure devices for other impairments may face procurement challenges.

Several organizations noted that improving the supply of assistive devices alone would not be an effective approach to improving AT access, reporting that:

- Stigma is high and, unless addressed, is likely to mean low take-up of devices among communities that hide children with disabilities;
- There are likely to be additional challenges around providing AT to women and internally displaced persons with AT needs, due to the marginalization they face;
- There needs to be concomitant training of sufficient physiotherapists and experts who can orient users in how to use their AT. For example, the distribution of low-cost devices such as white canes is of no value without associated orientation training;
- Doctors, nurses and other health professionals need to be made aware of what AT is available. A respondent pointed out that despite orthoses being equally as available as prostheses in Afghanistan, there is low take up of orthoses due to low awareness among health professionals (54).

Informants working in organizations with existing AT provision emphasized that scaling up operations was a challenge, because of limits to accessibility (particularly of remote, rural areas, and areas controlled by non-governmental forces). Many organizations pointed out that the real challenge was not provision per se, but the lack of provision outside Kabul and provincial capitals.

### **Barriers particular to the Afghan context**

In addition, key informant interviews identified a number of issues that do not appear in the global literature. These are mainly related to both government and donors falling short in meeting the AT needs of the population.

Respondents said they had no evidence of donor interest in disability issues generally (including the provision of AT). The lack of donor and international agency pressure was considered a key barrier to both government action on the issue, and to the availability of funding. The potential power and traction of donors and multilateral organizations prioritizing disability issues was expressed vividly by one respondent:

“It needs to be on every ministry’s agenda - just like women's issues were. It [women’s issues] was seriously a cross cutting issue. So, I think they

should do the same thing with disability. Everyone sitting round the table should be asking what are we doing on disability.” (32)

Low government capacity, and even government hostility to disability-related provision, was a significant concern for providers. Many international organisations recognized the importance of ownership of services by local organizations and government. However, there were concerns, based on experience, that handover to government would lead to either the destruction of established mechanisms for provision, or significantly lowering the quality of provision. One organization reported that as a result, their approach was to not provide free-of-cost devices as standard, but rather to means-test the costs of their provision, in order to build sustainability and reduce aid dependency.

Many key informants emphasized the Afghan policy environment was ostensibly strong, but that the government had failed to implement any disability-related policies, and despite ratifying the CRPD was not in compliance with it. This is a key structural barrier over which the only possible lever of influence is likely to be through pressure exerted by international donors that largely fund the public sector through the ARTF multi-donor trust fund.

One respondent pointed out Afghanistan’s cultural diversity, and how this must be considered in programming. One approach would not necessarily work in all parts of the country, due to differences in levels of education, geography, use of healthcare, and attitudes around disability. They argued that as a result, ‘scale up’ of a one-size-fits-all AT service was not a reasonable ambition: instead, providers need to “trial things [in context]. Show that the model works. Government [needs to] be able to reproduce it. We do not want foreign consultants who build something perfect with bells and whistles. [Afghanistan] need[s] basic, sustainable services.” (41).

## Recommendations

Annex A: Summary of AT provision and barriers to provision in Afghanistan

### Key

**Green** – global literature

**Purple** – grey literature on Afghanistan

**Blue** – Key informant interviews

|                                    |  |
|------------------------------------|--|
| <p>AT provision in Afghanistan</p> | <ul style="list-style-type: none"> <li>Physical rehabilitation centres providing mobility aids, run by ICRC, HI, SCA, KOO, DAO, RCY (all international and national NGOs) and government (39)(13)</li> <li>ARTF-funded BPHS includes provision of mobility aids through hospitals and community health centres. But interviews suggested this did not really take place (55)(51) and that almost all provision was by NGOs (39)</li> </ul> |
|------------------------------------|--|

|  |  |
|--|--|
|  | <ul style="list-style-type: none"> <li>• Save the Children conduct screening of disability for children, and provide cash support to meet children with disability’s specific needs (20)</li> <li>• SCA provides loans to families with children with disabilities, on condition that it is used to meet child’s needs (51)</li> <li>• HI runs a curriculum and training course for physiotherapists, prosthetic and orthotic technicians. HI also provides community-based psychosocial support and rehabilitation.</li> <li>• Gap in provision of AT (with possible exception of prosthetics), and particularly outside of provincial capitals (39)(45)(41)(51)(56)(57), particularly devices beyond mobility aids (44)(39)(37)(56)(57)</li> <li>• Low-tech devices, produced wholly or partly locally, are available. E.g., glasses and white canes (31)(39)</li> </ul> |
|--|--|

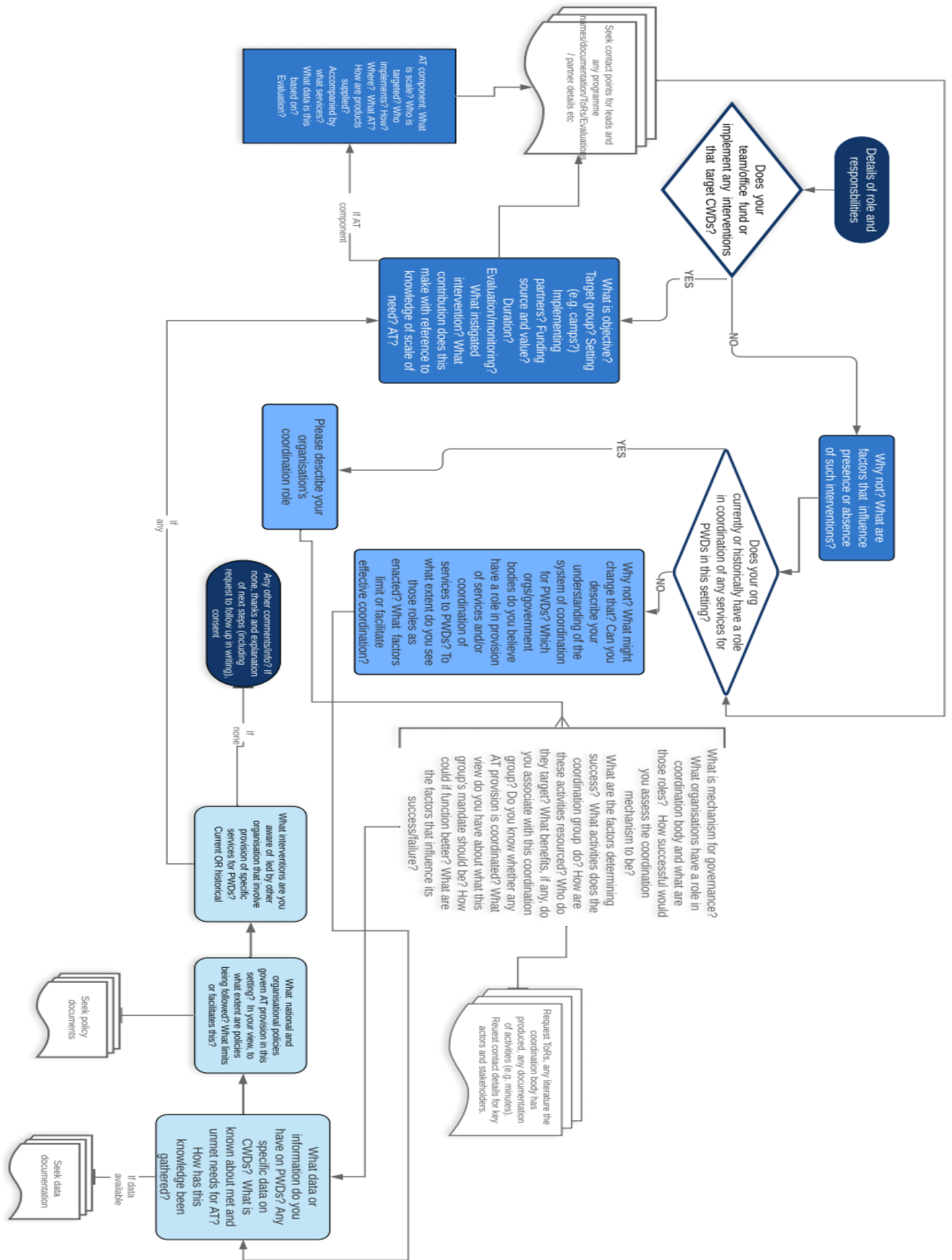
| Theme   | Barrier to provision/access   | Evidence   |
|---|---|--|
| Barriers in pre-existing context  | Centralized services are difficult to access for remote and rural populations   | (58)(59)(60)(61)<br>(62)(63)(64)(26)(57)(32)(41)(54)<br>(44)(51)(45)(56)         |
|   | Limited existing health infrastructure, including trained personnel, particularly with paediatric expertise           | (65)(66)(60)(67)<br>(68)(69)(70)(71)<br>(72)(73)(74)(26)(9,47)(75)(32)(54)(55)   |
|   | Limited existing AT market/manufacturing base/supply, particularly of quality products, particularly for children     | (76)(68)(77)(31)(75)(57)(32)<br>(41)   |
|   | Stigma and limited awareness of benefits by beneficiaries and their families, and by government and service providers | (77)(78)(59)(79)(73)(80)(81,82)(43)(42)(46)(29)(75)(37)(41)(44)(83)(20)(45) (56) |
|   | Limited data on met and unmet needs, and limited knowledge of best practice in data collection                        | (59)(69)(68)<br>(84)(85)(86)(74)(87)(44)(83)(20)<br>(33)                         |
|   | Poverty and prohibitively high healthcare costs   | (88)(85)(59)(54)   |
|   | Barriers resulting from crisis  | Worsened infrastructure (inc. health, transport, disability-specific services)   |
| Political or security restrictions limit access and provision of services |   | (54)(83)   |

|   |  |  |
|---|--|--|
|   | Children’s access to services reduced due to reliance on incapacitated family members  | (70)(93)(68)(94)   |
| Barriers resulting from nature of crisis response | Limited coordination/clarity on responsibility and leadership for AT provision, and lack of accountability mechanisms                                      | (95)(74)(96)(57)(53)(44)(20)(56)(33)   |
|   | Ineffective models of provision (e.g., NGO-led donations from HICs)  | (97)(95)(57)   |
|   | Prioritization of acute care over early rehabilitation, and mismatch between volume and types of needs and provision                                       | (98)(99)(100)(101)(95)(85)(37)(32)(44)(83)   |
|   | Shortage of funds available for AT from donors and government. Lack of political will and little donor interest/readiness to fund disability interventions | (31)(57)(37)(49)(53)(41)(54)(44)(55)(20)(50)(51)(56)   |
|   | Lack of expertise, capacity, technical knowledge, and awareness of AT needs among government, donors and NGOs to implement and develop programmes          | (102)(103)(104)(105)(72)(31)(57)(37)(32)(53)(41)(44)(20)(50)(31)(53)(44)(55)(45)(39)(33)(20)(57)(33) |
|   | Failure of government to implement policies  | (31)(37)(32)(53)(44)(51)(45)(56)   |
|   | Low government capacity to sustain services established by NGOs, and government corruption   | (57)(37)(53)(41)(44)(54)(83)(50)(51)   |
|   | OPDs not empowered by donors and government  | (37)(32)   |
| AT provision challenges                           | Cost of AT provision   | (99)(99)(106)(75)(37)(49)(41)(54)(50)(51)  |
|   | Heterogeneity of AT products   | (107)(107)   |
|   | Cost (time and financial) to tailor AT to setting and user   | (108)(67)(76)(109)(108)(67)(51)  |
|   | Need for ongoing services and provision  | (110)(61)  |
|   | Failure to accompany provision alongside sensitization and attitudinal change  | (37)(49)(32)(41)(44)(20)   |

**Annex B: Physical Rehabilitation centres in Afghanistan manufacturing orthopedic devices**

| Provinces  | MoPH     | ICRC     | SCA      | HI       | DAO      | RCY      | KOO      | HDDO     | AOD      | AABRAR   | TOTAL     |
|------------|----------|----------|----------|----------|----------|----------|----------|----------|----------|----------|-----------|
| Kabul      | 1        | 1        |          |          |          |          | 1        |          |          |          | 3         |
| Herat      |          | 1        |          |          |          |          |          |          |          |          | 1         |
| Kandahar   |          |          |          | 1        |          |          |          |          |          |          | 1         |
| Balkh      |          | 1        | 1        |          |          |          |          |          |          |          | 2         |
| Nangarhar  |          | 1        | 1        |          |          |          |          |          |          |          | 2         |
| Takhar     |          |          | 1        |          |          |          |          |          |          |          | 1         |
| Kapisa     |          | 1        |          |          |          |          |          |          |          |          | 1         |
| Badakhshan |          | 1        |          |          |          |          |          |          |          |          | 1         |
| Ghazni     |          |          | 1        |          |          |          |          |          |          |          | 1         |
| Faryab     |          |          |          |          |          | 1        |          |          |          |          | 1         |
| Helmand    |          | 1        |          |          |          |          |          |          |          |          | 1         |
| Khost      | 1        |          |          |          |          |          |          |          |          |          | 1         |
| Kunar      |          |          |          |          | 1        |          |          |          |          |          | 1         |
| Farah      |          |          |          |          |          |          |          |          |          | 1        | 1         |
| Zabul      |          |          |          |          | 1        |          |          |          |          |          | 1         |
| Paktya     |          |          |          |          |          |          |          |          |          | 1        | 1         |
| Baghlan    |          |          |          |          |          |          |          | 1        |          |          | 1         |
| Bamian     |          |          |          |          |          |          |          |          | 1        |          | 1         |
|            | <b>2</b> | <b>7</b> | <b>4</b> | <b>1</b> | <b>2</b> | <b>1</b> | <b>1</b> | <b>1</b> | <b>1</b> | <b>2</b> | <b>22</b> |

Annex C: Interview guide



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