Government of the Islamic Republic of Afghanistan

AFGHANISTAN NATIONAL DISABILITY ACTION PLAN 2008-2011

**to address the rights and needs of persons with disabilities, including mine survivors,
within the framework of the
Afghanistan National Development Strategy (ANDS) and the Anti-Personnel Mine Ban Convention**

Prepared for submission to the Government of the Islamic Republic of Afghanistan by

Ministry of Labor, Social Affairs, Martyrs and Disabled

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Introduction and Background

The Government of the Islamic Republic of Afghanistan's National Disability Action Plan 2008-2011 (ANDAP) was drafted in a consultative process under the auspices of the Ministry of Labor, Social Affairs, Martyrs and Disabled (MoLSAMD) following the revision of the Kabul Report – the plan of action to address the rights and needs of mine survivors and other persons with disabilities in Afghanistan in the period 2006 to 2009 – at the Second National Victim Assistance-Disability Workshop from 23-25 October 2007.[1] The ANDAP aims to address the rights and needs of all persons with disabilities, including mine survivors, within the framework of the Afghanistan National Development Strategy (ANDS) and the Convention on the Prohibition of the Use, Stockpiling, Production and Transfer of Anti-Personnel Mines and on Their Destruction (AP Mine Ban Convention).

The 2006 National Disability Survey in Afghanistan reported that 2.7 percent of the population has a disability, or about 800,000 people; including around 60,000 landmine survivors. Addressing the rights and needs of persons with disabilities is a complex issue. In Afghanistan, the complexities are exacerbated by the lack of or low quality of services within all areas of assistance including health care, social services, education and human rights. Lack of access to emergency services and health facilities in remote areas together with the lack of equipment, medicines, and adequately trained health and rehabilitation personnel, and insufficient levels of funding often prevent persons with disabilities and landmine/ERW casualties from receiving the care and rehabilitation services they need to survive and reintegrate into Afghan society.

Article 6.3 of the AP Mine Ban Convention obliges that each State Party "in a position to do so shall provide assistance for the care and rehabilitation, and social and economic reintegration of mine victims…" Afghanistan was one of 24 States Parties that reported a responsibility for significant numbers of mine survivors at the First Review Conference of the AP Mine Ban Convention, in Nairobi, Kenya, from 29 November to 3 December 2004.

At the First Review Conference States Parties adopted a clear understanding of principles to guide their efforts, including: that victim assistance efforts should not exclude any person injured or disabled in another manner; that assistance should be viewed as a part of a country's overall public health and social services systems and human rights frameworks; and, that providing assistance should be seen in a broader context of development and underdevelopment.

In the absence of national legislation to address the rights and needs of persons with disabilities, Afghanistan's international obligations under the AP Mine Ban Convention presented an opportunity to undertake activities to address these obligations and as a consequence address Afghanistan's obligations to all persons with disabilities in the country.

In August 2006, the Ministry of Foreign Affairs, with support from the Mine Action Center for Afghanistan (MACA) supported by the United Nations, convened the First National Victim Assistance Workshop with the aim of elaborating a plan of action for the period 2006-2009 to address the rights and needs of landmine survivors and other persons with disabilities as a first step towards meeting Afghanistan's obligations under the AP Mine Ban Convention, in relation to assisting the victims.

On 23-25 October 2007, the Second National Victim Assistance-Disability Workshop in Afghanistan was convened and hosted by the Ministry of Labor, Social Affairs, Martyrs and Disabled (MoLSAMD), again with support from UNMACA, at the Hotel Intercontinental in Kabul to review, revise and

[1] For more information on the workshop see Report of the Second National Victim Assistance Workshop

enhance the Kabul Report. The 2007 workshop brought together over 220 stakeholders, including representatives from nine ministries: Defense; Education; Foreign Affairs; Information and Culture; Labor, Social Affairs, Martyrs and Disabled; Public Health; Rural Rehabilitation and Development; Transport; and Women's Affairs. Ministerial colleagues came from Balkh, Gardez, Herat, Jelalabad, Kabul, Kandahar, Kunduz, and Mazar-i-Sherif. Other representatives came from the Parliament, from the Embassies of Canada, Germany, Japan, and the United States, the European Commission, 10 international agencies, around 38 national and international non government organizations, including disabled persons organizations.

The ANDAP was based on extensive deliberations at the Second National Workshop, and through inter-ministerial and key stakeholder consultations between November 2007 and April 2008. The ANDAP charts a more realistic and achievable way forward for the enhancement and expansion of current services for all people with disabilities, including landmine survivors, and their integration into social, educational and economic opportunities.

The consultative nature of this process will serve to strengthen national ownership of the objectives and actions elaborated, will support the achievement of the Millennium Development Goals, and will ensure continued integration of the objectives into the Afghanistan National Development Strategy. National ownership is particularly important as currently services for persons with disabilities are predominantly provided by international agencies and non governmental organizations with limited or no support from the national budget. The ANDAP will also serve to ensure that capacity building of the relevant Ministries continues following the end of the UNDP-supported National Program for Action on Disability (NPAD) in early 2008.

The format of the ANDAP includes an overview of the status, objectives elaborated in August 2006 and progress in achieving these objectives, together with revised objectives and actions for the period 2008 to 2011. Objectives were reviewed and where appropriate made less ambitious to take into account the particular challenges faced by the disability sector in Afghanistan, including: the lack of trained personnel and time needed to provide adequate training; the lack of financial resources; and the volatile security situation in parts of the country. The ANDAP covers the six key elements of victim assistance and two additional areas, community based rehabilitation and inclusive education, which have been identified as requiring more focused attention in the Afghanistan context:

- Part 1 – Understanding the extent of the challenge (data collection);
- Part 2 – Emergency and continuing medical care;
- Part 3 – Physical rehabilitation;
- Part 4 – Psychological support and social reintegration;
- Part 5 – Economic reintegration;
- Part 6 – Community based rehabilitation;
- Part 7 – Inclusive education; and,
- Part 8 – Laws and public policies

Full implementation of the ANDAP has the potential to make a significant difference in the daily lives of persons with disabilities and their families. It will benefit the disability sector as a whole as it is based on a positive consultative planning process that has established achievable benchmarks for a national disability program. By continuing to engage the disability sector in this process and in the implementation of the plan, the Government of Afghanistan can ensure that persons with disabilities, including landmine survivors, are fully integrated into Afghan society thus meeting its obligations under the AP Mine Ban Convention and its wider obligations to the population of Afghanistan.

Part 1: Understanding the extent of the challenge faced

Status:

Data from the National Disability Survey in Afghanistan (NDSA) indicates that, based on an estimated population of 25 million people, there are between 747,500 and 867,100 persons with severe disabilities in Afghanistan, of whom approximately 17 percent are war disabled (126,000 to 146,000). Between 52,000 and 60,000 people are landmine/ERW survivors; about 6.8 percent of the total number of people with disabilities. On average, one household in every five has a family member with a disability.

As of February 2008, the Mine Action Center for Afghanistan's (MACA) IMSMA database had recorded 17,487 landmine and explosive remnants of war (ERW) casualties since 1979, including 3,002 people killed and 14,485 injured; about 55 percent were under the age of 20 at the time of the incident and 92 percent of casualties are male.

Fieldwork for the NDSA, which was based on a random national cluster methodology, was completed in 2005. Results of the survey were finalized in early 2006 and shared with the Ministry of Labor, Social Affairs, Martyrs and Disabled (MoLSAMD), Central Statistic Office and the National Program for Action on Disability (NPAD).

Afghanistan is one of the most mine-affected countries in the world. The current rate of approximately 55 new mine/ERW casualties recorded by MACA per month is a significant decrease from 138 new casualties a month documented in 2001.

Mine/ERW casualty data collection began in 1998 and is an ongoing process on a national level in all impacted areas. Data on mine casualties was collected primarily by the International Committee of the Red Cross (ICRC) until July 2007 through a network of 490 health facilities supported by several agencies and organizations, including the Ministry of Public Health (MoPH), Afghan Red Crescent Society (ARC), International Federation of Red Cross and Red Crescent Societies, ICRC Orthopedic Centers, and more than a dozen NGOs and organizations. From July 2007, the ARC took over full responsibility for the landmine/ERW casualty data collection program. The ARC provides the UN Mine Action Program with 90-95 percent of its information on casualties. Agencies collecting data for ARC utilize a standardized format which is slightly modified to fulfill IMSMA database reporting formats. The available data is used by many of the organizations working with mine/ERW survivors and reporting mechanisms are being strengthened to provide data to relevant end users.

Data collected by the ICRC between 1998 and December 2005 indicates that 17 percent of casualties were killed. Types of injuries include: amputation of one or more limbs (37 percent), head injuries (7 percent), abdominal injuries (5 percent); eye injuries (4 percent); and other injuries (30 percent). By December 2005, the six ICRC orthopedic centers had registered more than 22,599 landmine/ERW amputees for services.

Strengthening of the MoPH information management systems to include injury surveillance is in the development stages. The World Health Organization's (WHO) country cooperation strategy for 2005 to 2009 includes a component on strengthening the surveillance system.

Little is known about the current location of survivors or their demographics. Tracking only occurs when additional medical or rehabilitation services are accessed. Mine/ERW casualties have been recorded in 32 of the 34 provinces of Afghanistan. According to MACA data, the majority of mine/ERW casualties were recorded in the provinces of Kabul (25 percent), Nangarhar (10 percent), Kandahar (8 percent), Herat (7 percent) and Parwan (6 percent).

Services are not equitably spread across all areas of the country and many people with disabilities lack appropriate care or must travel long distances to access it. For example, physical rehabilitation activities are available in only 80 out of 364 districts in 19 of 34 provinces in Afghanistan.

Prior to the completion of the NDSA there was insufficient data available on the socio-economic conditions of people with disabilities. However, it was recognized that people with a disability were among those in most socio-economically vulnerable situation in Afghanistan. The NDSA provided prevalence rates, statistical analysis and comprehensive information on the situation of persons with disabilities in Afghanistan with accompanying recommendations. For example, the NDSA found that 70 percent of people with a disability aged over 15 years are unemployed; 53 percent of males and 97 percent of females. In comparison, 25 percent of men and 94 percent of women without disability are unemployed. The NDSA also found that almost 73 percent of persons with disabilities above 6 years of age did not receive any education, whereas the rate is 51.4 percent for people without disability.

The last national census did not provide statistics on persons with disabilities. However, the planned 2008 National Census questionnaire has one question with five components on households with a family member with a disability.

Part 1: Understanding the extent of the challenge faced			
Goal:	**Objectives @ August 2006:**	**Revised objectives @ April 2008:**	**Actions to achieve revised objectives:**
Define the scale of the challenge, identify needs, monitor the responses to needs and evaluate the responses	• Maintain an up-to-date database on landmine/ERW casualties in Afghanistan – **ONGOING** • Set priorities based on available information on the situation of mine survivors and other persons with disabilities, by the end of 2006, for delivery or expansion of health care, rehabilitation, education, and socio-economic reintegration services, and awareness-raising campaigns – **ANALYSIS OF DATA COMPLETED AND RESULTS BEING TRANSLATED** • Create an up-to-date database on all disability services available in Afghanistan by mid 2007 – **NOT ACHIEVED** • Promote greater understanding of the socio-economic conditions of people with disabilities, including mine survivors – **SOME PROGRESS – ONE QUESTION WITH 4 COMPONENTS INCLUDED IN NATIONAL CENSUS QUESTIONNAIRE** • Integrate landmine casualty data into an injury surveillance mechanism, by 2009, in which persons with disabilities are tracked through the national health system – **SOME PROGRESS ON STRENGTHENING HEALTH INFORMATION SYSTEMS**	1. Up-to-date database on landmine/ERW casualties in Afghanistan maintained, on an ongoing basis. 2. Up-to-date database on all disability services available in Afghanistan created and disseminated, by the end of 2008. 3. Priorities based on available information on the situation of persons with disabilities, including mine survivors, developed by the end of 2009, for delivery or expansion of health care, rehabilitation, education, and socio-economic reintegration services, and awareness-raising campaigns. 4. Mechanism for monitoring and measuring progress in achieving objectives of the Afghanistan National Disability Action Plan (ANDAP) established, by the end of 2008.	1.1 MACA will continue to record mine/ERW casualty data in its IMSMA database for the duration of the mine action program. 1.2 The ARC will maintain its data collection network and share information, on an ongoing basis. 2. DSU of MoLSAMD, with support from MACA and other stakeholders, will: 2.1 Compile all existing information on agencies/NGOs working in the disability sector in Afghanistan, into an accessible database. 2.2 Disseminate information through mine/ERW data collection network. 3. DSU of MoLSAMD, in collaboration with other relevant ministries and stakeholders, will: 3.1 Analyze information from 2008 census on disability issues and NDSA (pending translation by Handicap International). 3.2 Draft priorities based on available information. 3.3 Disseminate information to all relevant actors in the disability sector, by the end of 2009. 4. DSU of MoLSAMD, with support from MACA and other relevant stakeholders, will: 4.1 Develop a standardized form to collect information from service providers on assistance provided to persons with disabilities, including mine/ERW survivors, by mid 2008. 4.2 Compile information on a regular basis and report to all relevant stakeholders working in the disability sector. 4.3 Produce an annual report to measure progress in achieving the objectives of the ANDAP and benchmarks in the ANDS and to highlight gaps in available services, starting in 2009.

Part 2: Emergency and continuing medical care

Status:

One of the stated working principles of the Ministry of Public Health (MoPH) in the period 2005-2009 is to give "priority to groups in greatest need, especially women, children, the disabled and those stricken with poverty." The MoPH delivers health services through the implementation of two main strategies initiated in 2002; the Basic Package of Health Services (BPHS) and the Essential Package of Hospital Services (EPHS). The strategies are currently under revision. The BPHS and EPHS are implemented through contract mechanisms with Health Care Providers (INGO/NGOs and agencies) by the Grand Contract Management Unit (GCMU). The MoPH is directly implementing BPHS in Panjshir, Parwan and Kapisa provinces. Since 2002, coverage of the BPHS has increased from 9 percent to 77 percent by March 2006, to 82 percent by March 2007, and to 85 percent by April 2008. In 2006, the EPHS was implemented in five hospitals increasing to 15 by the end of 2007 including Faizabad, Gardiz, Herat, Kandahar, Khost, Ghazni and Paktika Hospitals and hospitals in Kabul City. The BPHS is offered at four standard levels of health facility: Health Posts, Basic Health Center (BHC), Comprehensive Health Center (CHC) and District Hospital (first referral hospital). In 2005, there were 593 BHCs, 402 CHCs, 70 District hospitals, 31 Provincial hospitals, and 16 Regional Hospitals. The coordination of BPHS implementers and government at the provincial level is strong through PHCC (Provincial Health Coordination Committee) meetings, although the involvement of disability service providers is weak.

In the National Health Policy for 2005-2009, disability issues were moved from the second tier to the first tier in the BPHS. Disability is the 6th component of the BPHS package and includes the following services and activities: disability awareness, prevention and education; home visit program for paraplegics (in urban settings); treatment of war injuries and traumatic amputations; treatment of children with physical disabilities; assessments, treatments and referrals for persons with physical disabilities; inpatient and outpatient physiotherapy, and orthopedic diagnosis; and, referrals for fitting and training in the use of orthotics and prosthetics. Nevertheless, persons with disabilities continue to have difficulties accessing many health facilities due to physical inaccessibility and communication barriers.

Current challenges in providing health care services include acute shortages of specialized units, inappropriate and non-standardized infrastructure and facilities, lack of electricity, water supplies or sanitation systems, limited trained human resources particularly specialized physicians, lack of standard equipment, lack of facilities for family members or facilitators for persons with disabilities, limited financial resources, problems with accessibility caused by lack of roads and public transport, and insecurity in some parts of the country. It is reported that it will take 5-10 years for medical faculties at the Institute of Health Sciences (Ghazanfar Institute) to train sufficient graduates to cover the BPHS and EPHS, but some of these refuse to work in rural areas. Other estimates measure the time needed as decades not years. To overcome these challenges, MoPH reports that it is taking a number of steps, including: mobilizing and training more female staff; increasing the number of health facilities with female staff; creating sub-centers and deploying mobile teams for the expansion of BPHS in remote and rural areas; and providing refresher training opportunities for health staff. By 2007, 12 mobile health facilities had been established to provide basic health services to the nomadic Kuchi population.

Basic first aid services are available through Health Posts at the community level by community health workers (one male and one female). The 2004 Afghanistan Landmine Impact Survey (LIS) found that only 10 percent of mine-impacted communities had healthcare facilities of any kind. There are pre-hospital care services available for mine casualties through health facilities (Health Posts, BHCs and CHCs). Some international agencies and INGO/NGOs provide first aid training for community-based health volunteers in the care of traumatic injuries. All hospitals have an emergency room. There is well-designed mechanism to register mine/ERW casualties at the provincial level throughout the country under the Mine Action Program for Afghanistan.

Trauma care specialists are not widely available. Safe intravenous serum is available in most hospitals and health facilities. Blood transfusions are available in district, regional and provincial hospitals and some CHCs. All district hospitals have full laboratory facilities. Some CHCs have laboratory testing

available but some do not have facilities to test for HIV/AIDs, Hepatitis and other complex testing procedures. The general population does not have adequate information or access to emergency response services and ambulances. Ambulances are not available at all hospital facilities in Afghanistan. In Kabul there is an overstretched city-wide response through the Kabul Ambulance Service which is transitioning to the MoPH. Public and private transport by taxi and local transport, and in rural areas by donkey, horse and mule, is available to most people for transfer to health facilities. Access to emergency first response for most mine/ERW casualties can take between one hour to three days depending on location of the incident, security situation, accessibility, availability of transport, and road and weather conditions. It has been reported that in some circumstances reaching health facilities can take 5-6 hours. ISAF/NATO assists in evacuation of war/mine casualties to hospital from incident sites in their coverage areas.

Amputation is available in hospitals, though upgrading of the quality of services is required in some areas. There is sometimes, and particularly in some areas, inadequate equipment and supplies in health facilities which affects the quality of services. Formal training is not available on emergency response for the care of traumatic injuries. There is a need for training of nurses and paramedics in the care of traumatic injuries at the district hospital level. Some INGOs provide short-term training for surgeons and nurses, in collaboration with the MoPH and Ghazanfar University in their coverage areas.

WHO's Cooperation Strategy with the MoPH for the period 2006 to 2009 includes a component on building capacity in the area of emergency preparedness and response. Since 2006, WHO has been collaborating with the MoPH to build capacities in emergency and essential surgical and anesthesia procedures at regional and provincial hospitals through the Integrated Management for Emergency and Essential Surgical Care program.

Although pain medication for mine casualties should be available, only about 20 percent of mine casualties report access to pain relief. The BPHS includes the provision of medicines for pain management of emergencies and other traumatic injuries. However, in terms of pain management for emergency response including for mine/ERW casualties these provisions need to be updated.

Access to corrective surgery including plastic surgery and post-amputation revisions is often needed and available in provincial and regional hospitals. Ophthalmology and auditory medical care is very limited, even in big cities. Persons with disabilities are referred to rehabilitation services, which are available in 19 of the 34 provinces. Some home-based health care/rehabilitation services are provided by INGOs within their coverage area.

Mine/ERW casualties will not be turned away or denied services; however long term care is more difficult due to costs of health care, transportation and lodging. Women may be denied care either by their family or refusing treatment themselves from male practitioners. Services are available equally to all; however cultural barriers are known to restrict women and girls from services as female doctors and practitioners may not be available. In 2007, MoPH reported that 70 percent of health facilities had at least one female staff as compared to less than 45 percent in 2001.

In 2006, MoPH established a Disability Taskforce with the objectives of: improving coordination and cooperation between different sections of MoPH, MoLSAMD, and disability organizations and service providers; raising the priority and awareness of disability issues; resolving outstanding issues relating to disability; establishing a disability department; and resource mobilization and sensitization of donors to support disability services within the BPHS and EPHS. MoPH also has a Disability Department which provides support on policy making and coordination of physical rehabilitation services and reports directly to the Director General of Primary Health Care Directorate.

The Physical Rehabilitation Guideline has been developed by the Disability Department in collaboration with the Disability Taskforce for MoPH in order to provide recommendations to health care providers on the inclusion of disability in the BPHS. However, considering the need for physical rehabilitation services around the country the number of physical rehabilitation professionals including orthopedic technicians and physiotherapists is inadequate. There are only 245 physiotherapists and physiotherapy assistants working in the country. The Disability Department also developed the Disability Awareness and Physical Rehabilitation Manual and the Resource Book on Psychosocial Rehabilitation.

Part 2: Emergency and continuing medical care			
Goal: Reduce deaths by stabilizing medical conditions and minimizing physical impairments in emergency settings that could result from injury	**Objectives @ August 2006:** ▪ Create a directory of all emergency and continuing medical care services in mine/ERW-impacted rural areas by the end of 2006 – **NOT ACHIEVED.** ▪ Create a directory of all emergency and continuing medical care services in Afghanistan by the end of 2007 – **NOT ACHIEVED** ▪ Establish a mechanism to improve coordination among relevant actors at the national, regional and local levels by the end of 2006 – **SOME PROGRESS** ▪ Increase access to emergency pre-hospital response services in all heavily mine/ERW-impacted rural areas in order to reduce the mortality rate of mine/ ERW casualties (not killed immediately by the explosion) by 75 percent by 2009 – **SOME PROGRESS** ▪ Develop an emergency evacuation capability in 50 remote districts by 2009 – **SOME PROGRESS** ▪ Expand the implementation of the EPHS to 20 hospitals by 2009 – **15 BY END OF 2007** ▪ Train at least 50 trauma care specialists, including surgeons, anesthetists, and nurses, by 2009 – **SOME PROGRESS** ▪ Increase the capacity of MoPH personnel, in terms of disability,	**Revised objectives @ April 2008:** 1. Directory of all emergency and continuing medical care services/providers in Afghanistan created and disseminated by the end of 2008. 2. Emergency pre-hospital response capabilities enhanced in all heavily mine/ERW-impacted areas in order to reduce the mortality rate of mine/ ERW casualties (not killed immediately by the explosion) by 75 percent by 2009. 3. An emergency evacuation capability developed in 50 remote districts by 2009. 4. Quality of, and access to, trauma services increased, on an ongoing basis.	**Actions to achieve revised objectives:** 1. MoPH, in collaboration with other relevant stakeholders, will: 1.1 Create an accessible directory of all emergency and continuing medical care services in Afghanistan by the end of 2008, and update as required. 1.2 Disseminate directory in all heavily mine/ERW impacted areas, with support from MACA, by the end of 2008. 2. MoPH, in collaboration with other relevant stakeholders and implementing partners, will: 2.1 Ensure health facilities have emergency care equipment, supplies and trained personnel. 2.2 Develop an emergency evacuation strategy for heavily impacted communities by the end of 2008. 2.3 Implement a training, or refresher training program, for community based workers in impacted areas, in first aid for traumatic injuries. 2.4 Disseminate guidelines on trauma care and first aid. 2.5 Coordinate with all actors in the field, including Area Mine Action Centers and Mine Risk Education teams, on an ongoing basis. 3. MoPH, in collaboration with implementing partners and other relevant stakeholders including ISAF and MACA, will develop the infrastructure to provide emergency evacuations in remote areas. 4. MoPH, in collaboration with implementing partners and other relevant stakeholders, will: 4.1 Train at least 34 trauma care specialists (doctors, surgeons, anesthetists and nurses) by 2009. 4.2 Develop and implement a trauma training program in Afghanistan. 4.3 Identify opportunities under overseas fellowship programs in trauma care. 4.4 Increased the number of women trained as trauma care specialists, on an ongoing basis. 4.5 Develop and adopt Afghanistan-specific Trauma Care

	to take the lead in the coordination of rehabilitation activities by 2009 – **DISABILITY AWARENESS PACKAGES AND PILOT TRAINING DEVELOPED IN BADAKHSHAN** ▪ Develop guidelines to implement BPHS Disability Services for the country by 2007 – **ACHIEVED** ▪ Improve access to the primary healthcare system in at least 50 remote rural areas by 2009 – **SOME PROGRESS** ▪ Equip hospitals and health facilities serving at least 50 percent of heavily mine/ERW-impacted rural areas with adequately trained personnel, equipment and supplies by 2009 – **SOME PROGRESS** ▪ Include appropriate training on disability issues, including disability prevention, early detection and interventions through medical and social rehabilitation, in the curriculum for all institutions providing training for medical and paramedical health personnel by 2009 – **SOME PROGRESS** ▪ Provide support services, such as clinical psychology, physiotherapy, occupational therapy, audiology, speech therapy, and counseling, with adequately trained personnel in major hospitals in at least five provinces by 2009 **– SOME PROGRESS**	5. Implementation of the EPHS expanded to 50 percent of provincial and regional hospitals by 2010. 6. Access to the primary healthcare system in at least 50 remote rural areas improved by 2010. 7. Hospitals and health facilities serving at least 50 percent of heavily mine/ERW-impacted rural areas equipped with adequately trained personnel, equipment and supplies by 2010. 8. Support services, such as physiotherapy, audiology, speech therapy, and counseling, with adequately trained personnel provided in major hospitals in at least five provinces by 2010. 9. The number of trained female healthcare providers increased by at least 50 percent by 2010 to improve access to services for women, including women with disabilities.	Guidelines by the end of 2008. 4.6 Implement guidelines on trauma care in hospitals implementing the EPHS, on an ongoing basis, starting in 2009. 4.7 Expand the implementation of the WHO's Integrated Management for Emergency and Essential Surgical Care program in at least 5 more hospitals, by 2010. 5. MoPH, in collaboration with implementing partners and other relevant stakeholders, will fully implement the EPHS in the target hospitals, to meet the benchmarks outlined in the ANDS by 2010. 6. MoPH, in collaboration with implementing partners and other relevant stakeholders including the Ministry of Transport, will establish transportation services or mobile clinics to improve access to primary healthcare in remote areas by 2010. 7. MoPH, in collaboration with implementing partners and other relevant stakeholders, will fully implement the provisions of the BPHS and EPHS in the target areas, to meet the benchmarks outlined in the ANDS by 2010. 8. MoPH, in collaboration with implementing partners and other relevant stakeholders, will fully implement the provisions of the BPHS, EPHS, and the disability guidelines in target hospitals, by 2010. 9. MoPH, in collaboration with implementing partners and other relevant stakeholders, will: 9.1 Increase the representation of women in healthcare training programs. 9.2 Create opportunities for women to attain the necessary educational prerequisites to undertake healthcare training at the community level, on an ongoing basis. 9.3 Disseminate BPHS Disability guidelines to all health facilities.

	▪ Increase the number of trained female healthcare providers by 50 percent by 2009 to improve services available for women with disabilities – **SOME PROGRESS** ▪ Maintain disability as one of the top priorities in the work of the MoPH during the period 2006-2009, and beyond – **SOME PROGRESS**	10. Appropriate training on disability issues, including disability prevention, early detection and interventions through medical and social rehabilitation, included in the curriculum for all institutions providing training for medical and paramedical health personnel by 2009. 11. Community and institutional awareness on disability increased, on an ongoing basis.	10. Disability Department of MoPH, in collaboration with the Institute of Health Sciences and other relevant national and international organizations, will finalize the disability education curriculum by the end of 2008. 11. Disability Department of MoPH, in collaboration with implementing partners and other relevant stakeholders, will: 11.1 Conduct disability awareness training at health facilities and at the community level, on an ongoing basis. 11.2 Disseminate BPHS Disability guidelines to all health facilities.

Part 3: Physical rehabilitation

Status:

Physical Rehabilitation services for all persons with disabilities, regardless of the cause, are a part of a broader social policy and a combination of medical, psychological and social services. However, the physical rehabilitation needs of mine/ERW (Explosive Remnants of War) survivors and other persons with disabilities are not being completely met. Rehabilitation services, including orthopedic and physiotherapy services are mostly in urban areas with the exceptions of some rehabilitation services available in rural areas. Physical rehabilitation services were started by disability NGOs who saw the needs in refugee populations and in urban and rural areas. Physical rehabilitation services are also delivered as part of Community Based Rehabilitation (CBR) programs. Many persons with disabilities have difficulty in accessing existing services or are unaware of the services that are available.

Physical rehabilitation activities are conducted in 19 of the 34 provinces in Afghanistan:

- Physiotherapy services exist in 19 provinces (Badakhshan, Baghlan, Balkh, Bamyan, Faryab, Ghazni, Herat, Jowzjan, Kabul, Kandahar, Kunar, Konduz, Laghman, Lowgar, Nangarhar, Parwan, Samangan, Takhar, and Wardak); and,
- 14 orthopedic workshops operate in 10 cities in 10 provinces [Faizabad (Badakhshan), Mazar-i-Sharif (2 – Balkh), Maimana City (Faryab), Ghazni City (Ghazni), Herat City (Herat), Kabul City (3 – Kabul), Kandahar City (Kandahar), Jalalabad (2 - Nangarhar), Gulbahar (Parwan), and Taloqan (Takhar)].

There are gaps in terms of access to physical rehabilitation services in Afghanistan. Construction of a new rehabilitation center for orthopedic services in Khost was completed in 2006; however, the center is not functioning as it lacks fully trained staff and an operating budget and is in an region with considerable security problems.

In total, there are 347 trained physiotherapists and physiotherapy assistants in the country, of which 245 are currently working. There are also 340 technical staff including 126 orthopedic technicians and 105 artisans providing orthopedic services.

Rehabilitation and related services are provided by several INGO/NGOs through orthopedic workshops, physiotherapy clinics, community based programs and outreach programs. Most of the physical rehabilitation centers with orthopedic workshops also provide, or refer clients to, free medical care, physical rehabilitation, psychosocial support, vocational training, revolving loans for small business, and public awareness services related to government rules and programs.

There is one center for paraplegics in Kabul; however, the quality of services needs to be improved. A few INGOs and agencies assist paraplegics through home-care projects.

One private orthopedic workshop has opened in Kabul for those who can afford it.

Physiotherapy training is provided by the Physiotherapy Training Institute (PTI) of Kabul through the mandate of the MoPH Institute of Health Sciences (IHS/Ghazanfar Institute). Physiotherapy training and upgrading is also carried out in Jalalabad and Mazar-i-Sharif under the regional IHS departments.

A national physiotherapy curriculum review by disability stakeholders to increase the 2-year Physiotherapy diploma to a 3-year diploma was finalized in 2007 with the commencement of the first course for physiotherapy teachers and physiotherapy clinical supervisors.

Training of technicians and physiotherapists is provided by INGO/NGOs and agencies through their physical rehabilitation programs. Upgrading to a 2-year diploma for orthopedic technicians has been run in the different orthopedic workshops. In 2008, a 3-year diploma course for orthopedic technicians will start.

Initial and upgrading training of technicians and physiotherapists is provided by INGO/NGOs and agencies in their own centers. Upgrading courses for a 2-year diploma for orthopedic technicians have been run by the ICRC since 2004 with a curriculum approved by IHS; 80 technicians have graduated from 4 courses. In 2008, ICRC will start a 3-year diploma course for orthopedic technicians in Kabul under IHS auspices.

The Afghan Association of Physiotherapists (AAPT) was established in 1998 and in 2007 became a member of the World Confederation of Physical Therapy (WCPT). AAPT was registered as a professional association by MoPH in 2008.

The Guideline for Physical Rehabilitation was developed by MoPH in cooperation with the Disability Taskforce/Disability Department in 2007 for implementation by primary health care providers. In addition the Resource Book on Psychosocial Rehabilitation was developed by the MoPH Disability Department for implementation by CBR program workers. The Disability Department also developed a Disability Awareness and Physical Rehabilitation Manual for health care providers in 2007.

Access to rehabilitative care is mainly available free of charge. Some physiotherapy centers charge a small amount from non-disabled clients. This money is utilized for those who cannot afford transport to the centers. Distance and related costs (transport, accommodation, and Mohram for women, etc) can be problematic in areas where services are not available. Access to services is immediate in most cases when people arrive at centers. However, there are waiting lists for the production of wheelchairs and specialized assistive devices. There is no funding support from the MoPH for rehabilitation services at the present time, even though disability services are included in the MoPH's BPHS and EPHS. MoPH needs to lobby donors to provide support for these services which are currently provided by INGOs and NGOs.

The components for prosthetics, orthotics, wheelchairs and walking aids are produced and available locally. Some raw materials and components are being imported by the orthopedic workshops due to lack of availability of suitable materials on the local market.

The Disability Department of MoPH has coordinating responsibility among disability stakeholders; however, the coordination could be improved with line ministries and to avoid duplication of services.

In 2006, MoPH established a Disability Taskforce with the objective of improving coordination and cooperation between different sections of MoPH, disability organizations and health care service providers; it is functioning well.

Part 3: Physical rehabilitation			
Goal: To prevent disability and restore maximum physical functional ability for persons with disabilities, including landmine survivors.	**Objectives @ August 2006:** ▪ Create a directory of all physical rehabilitation services in Afghanistan by the end of 2006 – **ACTIVITIES STARTED** ▪ Disseminate the directory of physical rehabilitation services in Afghanistan to all mine/ERW-affected communities by the end of 2007 – **ACTIVITIES STARTED** ▪ Increase access to physical rehabilitation services by at least 10-20 percent for persons with disabilities by 2009 – **SOME INCREASE IN SERVICES PROVIDED** ▪ Increase the output of prosthetic and orthotic workshops by at least 5 percent per year, and improve the quality – **SOME INCREASE IN OUTPUT AND REFRESHER TRAINING** ▪ Improve accessibility in provinces without disability services by establishing appropriate services in one additional province each year – **SOME EXPANSION** ▪ Improve accessibility in at least five provinces without disability services by 2009 through the provision of transport to appropriate physical rehabilitation facilities – **NO REPORTED PROGRESS** ▪ Improve accessibility in provinces with disability services by establishing mobile outreach units that visit at least 30 percent of remote heavily mine/ERW-impacted areas by 2009 – **SOME OUTREACH IN PLACE**	**Revised objectives @ April 2008:** 1. Directory of all physical rehabilitation services in Afghanistan disseminated by the end of 2008. 2. Access to physical rehabilitation services for persons with disabilities increased by the end of 2010.	**Actions to achieve revised objectives:** 1. Disability Department of MoPH, in collaboration with other relevant stakeholders will: 1.1. Compile all the information submitted on available regarding the available physical rehabilitation services, including at health facilities, into a directory for dissemination by mid-2008. 1.2. Coordinate delivery and dissemination of directory through health facilities, the CBR network, and agencies implementing the BPHS and EPHS, DPOs, and other disability and development organizations by the third quarter of 2008 2. Disability Department of MoPH in collaboration with other relevant stakeholders will: 2.1 Utilize the standard format developed to collect statistics on physical rehabilitation services provided to persons with disabilities by all relevant organizations as a means to monitor increases in service provision, on an ongoing basis. 2.2 Increase the number of persons with disabilities assisted with mobility aids through the establishment of orthopedic workshops in areas currently uncovered, by end of 2010. 2.3 Build the capacity of existing orthopedic workshops to start outreach services and upgrade the skills of technician by end of 2010. 2.4 Develop a baseline and improve accessibility at 2 percent of health facilities by the end of 2009. 2.5 Deliver physiotherapy services through 20 percent of BPHS facilities by the end of 2010. 2.6 Develop reporting and monitoring mechanism for disability related activities within the health system through the HMIS of MoPH by the end of 2008. 2.7 Lobby and advocate for the expansion of services to those areas where no services are available through the financial support of National development budget and other traditional donors by the end of 2010 2.8 Develop a strategy for MoPH for the specific and mainstreaming physical rehabilitation program within the system of MoPH by 2011.

	▪ Establish physical therapy clinics, with adequately trained personnel, in at least 5 percent of district, provincial and regional hospitals by 2009 – **MORE THAN 50 PERCENT OF PHYSIOTHERAPY SERVICES (MOSTLY RUN BY NGOs AND NOT PART OF BPHS) ARE ALREADY IN HOSPITAL/CHC COMPOUNDS** ▪ Increase the number of trained physiotherapists and technicians by at least 5 percent each year, ensuring that at least 30 percent of trainees are people with a disability – **NOT ACHIEVABLE DUE TO TRANSITION FROM 2 TO 3 YEARS TRAINING** ▪ Increase the number of trained female rehabilitation providers by 20 percent by 2009 to improve services available for women with disabilities – **NO REPORTED PROGRESS** ▪ Provide refresher training to at least 10 percent of rehabilitation providers per year **– ACHIEVED** ▪ Establish a mechanism to improve coordination among relevant actors at the national, regional and local levels by mid 2007 – **ACHIEVED AT NATIONAL LEVEL**	3. Capacity building of health care and rehabilitation providers, including MoPH staff and NGOs, to provide quality rehabilitation services increased by 2010. 4. Professions of physiotherapists and orthopedic technicians formally recognized by 2009. 5. The Disability Taskforce strengthened to improve coordination among relevant stakeholders at the national, regional and local levels by the end of 2009.	3. Disability Department of MoPH in collaboration with other relevant stakeholders will: 3.1. Translate the Disability Awareness and Physical Rehabilitation Manual into local languages and disseminate to all mine/ERW-affected communities, health facilities and disability stakeholders by the end of the 3rd Quarter 2008. 3.2. Translate, disseminate and implement the Physical Rehabilitation Guidelines at MoPH health facilities by mid 2008. 3.3. Integrate disability related topics into the curriculum of health staff (in particular, nurses, doctors and health administrators) by the end of 2008. 3.4. Implement awareness-raising and training courses for MoPH staff. 3.5. Promote disability awareness through provincial hospitals, district hospitals, basic health centers and community health centers, particularly in areas where there are no rehabilitation services, on an ongoing basis. 3.6. Increase the number of rehabilitation trainers from 2009. 3.7. Provide refresher training to at least 10 percent of rehabilitation providers per year. 3.8. Increase the number of physiotherapists and orthopedic technicians, especially female professionals and persons with disabilities, in training by 2010, including through the expansion of training facilities, by the end of 2010. 4. Disability Department of MoPH, in collaboration with other relevant stakeholders, will: 4.1 Develop an appropriate testing certification mechanism to assess the qualifications of physiotherapists and orthopedic technicians, by the end of 2008. 4.2 Establish a Testing Certification Committee to assess qualifications of physiotherapists and orthopedic technicians, by 2009. 4.3 Achieve formal recognition of professions by MoPH by the end of 2009. 5. Disability Department of MoPH and organizations working in the field of physical rehabilitation will: 5.1. Convene regular meetings of the Disability Taskforce which include the participation of all relevant physical

			rehabilitation providers at the national, regional and local level. 5.2. Create a mechanism to collect information and report on activities in the disability sector, on a regular basis, to improve planning and decision making at the national, regional and local levels, to avoid duplication in the delivery of disability services, by mid-2008. 5.3. Support networks with other regional and international institutions in the rehabilitation field, including WCPT/ISPO, on an ongoing basis. 5.4. Facilitate regular reporting and sharing of resources and expertise, on an ongoing basis 5.5. Ensure involvement of people with disabilities in the work of the taskforce on an ongoing basis.
		6. Institutional capacity of MoPH to define policy and formulate strategies in the field of disability increased by 2010.	6.1 Disability Department of MoPH, in collaboration with relevant stakeholders, will develop a disability and rehabilitation strategy for the health sector, according to the guidelines of the National Health and Nutrition Strategy, for approval by 2009. 6.2 MoPH will recruit permanent staff in the Disability Department by 2010. 6.3 Maintain disability as one of the top priorities for MoPH during the period 2008-2010, and beyond.

Part 4: Psychological support and social reintegration

Status:

Post-traumatic stress disorder is common among people with disabilities caused by traumatic injury. However, there are few psychosocial support activities in Afghanistan or guidelines for mental health. The stigma related to disability and mental health issues adds to the stress for persons with disabilities. The issue of mental health has been moved to the first tier under the revised BPHS.

The WHO's country cooperation strategy with the MoPH for 2006 to 2009 includes a component on mental health. The aims of WHO support include: the development of a national policy on mental health; the establishment of appropriate institutions; incorporating mental health into the curriculum for training of relevant health staff; and focusing on the special needs of women.

The MoPH Coordination Group on Health (CGHN) has discussed the issue of disability and psychosocial rehabilitation. However, activities are mainly focused on Kabul and need to be expanded to other provinces.

The Resource Book Psychosocial Rehabilitation Manual for Health Care Providers was drafted by Disability Department of MoPH in 2007. The Disability Department also developed a Disability Awareness and Physical Rehabilitation Manual for health care providers in 2007.

There is no coordination of relevant actors on a national level. Some initiatives exist through international NGOs directed at specific needs or one-off projects. INGOs also support centers which provide psychological support for all Afghans, including people with a disability. There is also limited peer support through service providers who employ large numbers of persons with disabilities. New peer support programs through NGOs are planned for 2008.

There is a lack of awareness within the general population on disability and access issues, the lack of opportunities for people with a disability, and on the capacity of people with disabilities to be productive members of their community.

There are increasing opportunities for people with disabilities to participate in sporting activities. The Afghan Paralympics Foundation was established in 2003 and now has around 2,500 athletes in six provinces. However, there is a lack of suitable sports grounds, transport, equipment and trainers to expand programs.

Currently, there is no academic institute to train Social Workers in the country. Limited short courses on the issue of social work are conducted by some INGOs.

Part 4: Psychological support and social reintegration			
Goal: To assist landmine survivors, including children, to resume their role in the community by helping them cope with psychosocial adjustment issues and assisting them to regain and maintain a healthy and positive outlook on life.	**Objectives @ August 2006:** ▪ Create a directory of all psychological support and social reintegration services in Afghanistan by the end of 2006 – **NOT ACHIEVED** ▪ Disseminate the directory of psychological support and social reintegration services in Afghanistan to all mine/ERW-affected communities, as appropriate, by the end of 2007 – **NOT ACHIEVED** ▪ Establish a mechanism to address the huge gap in psychosocial support services and improve coordination among relevant actors at the national, regional and local levels by the end of 2006 – **NOT ACHIEVED** ▪ Introduce a training program, as part of the BPHS, for community healthcare and other service providers on psychosocial and disability issues by the end of 2007 – **PSYCHOLOGICAL AWARENESS PACKAGE DEVELOPED** ▪ Introduce a program to provide formal training for specialized social workers in Afghanistan by the end of 2007 – **TRAINING PACKAGE DEVELOPED** ▪ Expand programs for sport for people with disabilities, on an ongoing basis – **SOME PROGRESS** ▪ Increased accessibility to sporting and social activities, and schools	**Revised objectives @ April 2008:** 1. Directory of all psychological support and social reintegration services in Afghanistan created and disseminated by the end of 2009. 2. Access of persons with disabilities, including landmine survivors, to psychosocial rehabilitation services expanded, on an ongoing basis. 3. Existing programs on sport and recreation for people with disabilities, including landmine survivors, expanded, on an ongoing basis.	**Actions to achieve revised objectives:** 1. Disability Department of MoPH, in collaboration with the DSU of MoLSAMD and other relevant stakeholders, will: 1.1. Create a directory of all psychological support and social reintegration services in Afghanistan and compile into an accessible database, by the end of 2008. 1.2. Disseminate the directory of psychological support and social reintegration services in Afghanistan to all mine/ERW-affected communities, as appropriate, by the end of 2009. 2. Mental Health Department of MoPH, with support from Disability Department and implementing partners, will: 2.1. Deliver psychosocial rehabilitation services through BPHS and EPHS from 2008. 2.2. Integrate psychosocial rehabilitation services into the HMIS (Health Management Information System) by the end of the 2nd quarter of 2008. 2.3. Undertake one week training of BPHS providers and Provincial MoPH staff in disability awareness and psychosocial rehabilitation through Training of Trainers and implement in at least 10 provinces from 2008. 2.4. Provide on-going training to Health Facility and Community Rehabilitation and Development Centers staff and Community Health (CHWs) and Community Rehabilitation (CRWs) Workers on psychosocial rehabilitation from 2008. 2.5. Implement new peer support programs from 2008. 2.6. Coordinate psychosocial rehabilitation activities at the national and sub national level from 2008. 2.7. In collaboration with DSU of MoLSAMD, provide psychosocial rehabilitation services to persons with disabilities, including landmine survivors, through disability resource and training centers from mid-2008. 3.1. MoLSAMD, in collaboration with other relevant stakeholders, will advocate for increased resources and facilities, and to encourage the inclusion of sporting activities for persons with disabilities in the school

	for people with disabilities in all major cities in Afghanistan by 2009 – **NO REPORTED PROGRESS** ▪ Conduct awareness-raising programs throughout the country on the rights and capacities of people with disabilities, and in particular women with disabilities, in 2007 and beyond – **ACHIEVED 2007 AND ACTIVITIES ONGOING**	4. Social Work training facility established within Ghazanfar Health Institute by the end of 2009.	curriculum. 3.2. Kabul Municipality, in collaboration with the DSU of MoLSAMD, will establish an accessible park for persons with disabilities, including landmine survivors, in Kabul City in 2008. 3.3. Kabul Municipality, in collaboration with the DSU of MoLSAMD, will establish green areas in disability resource centers from 2008. 4. Disability Department of MoPH, in collaboration with the Ghazanfar Health Institute and other relevant stakeholders, will: 4.1. Implement the curriculum for a two-year specialized training course for social workers. 4.2. Establish a taskforce with a specific ToR on the establishment of a Social Work Institute/department within Ghazanfar Health Institute by the end of 2nd quarter 2008. 4.3. Establish a Social Work Institute/ Department within Ghazanfar Health Institute by the end of 2009.
		5. Accessibility to sporting and social activities, and schools for people with disabilities in all major cities in Afghanistan increased by 2009.	5. DSU of MoLSAMD, in collaboration with other relevant stakeholders, will advocate for the Ministry of Transport to provide specially equipped buses for transportation of people with disabilities and their families to sporting and social activities and schools by 2009.
		6. Awareness-raising programs throughout the country on the rights and capacities of people with disabilities, and in particular women with disabilities, conducted on an ongoing basis.	6. DSU of MoLSAMD, in collaboration with other relevant stakeholders, will develop and coordinate a campaign using radio, television, print media, workshops, a mobile theatre, and special activities such as a Disability Week.

Part 5: Economic reintegration

Status:

According to the *Afghanistan Human Development Report 2004*, approximately 53 percent of Afghans live below the poverty line and the average person spends approximately 80 percent of their income on food.

The NDSA found that 70 percent of people with a disability aged over 15 years are unemployed; 53 percent of males and 97 percent of females. In comparison, 25 percent of men and 94 percent of women without disability are unemployed.

Data from the Afghanistan Landmine Impact Survey indicated that unemployment among mine survivors increased by 38 percent after the incident. There were notable decreases in the percentage of survivors who continued to be farmers, herders, military personnel, deminers, and laborers – all occupations requiring mobility over difficult terrain (a challenge for amputees) – and increases in the numbers of survivors doing household work and being unemployed.

The MoLSAMD plays a key role in integrating of persons with disabilities into mainstream vocational training programs through the National Development Skill Program; however, coordination with the MoE could be improved.

MoLSAMD has opened 13 vocational training centers; 10 percent of beneficiaries are people with disabilities. MoLSAMD had a presence in 32 of the 34 provinces with vocational training programs. The results of such activities have not been particularly good due to lack of adequate funding, lack of infrastructure and lack of employment opportunities after the training is completed. The quality of vocational training needs to be further improved. MoLSAMD plans to replicate the vocational training program in other provinces in the coming years.

Employment support and vocational training programs are also being conducted by international agencies and NGOs in 15 provinces (Badakhshan, Baghlan, Balkh, Bamyan, Ghazni, Jozjan, Kabul, Kunar, Kunduz, Laghman, Logar, Nangarhar, Samangan, Takhar, and Wardak). INGO/NGOs operate at least eight vocational training schools in cooperation with MoLSAMD.

The UNDP National Program for Action on Disability (NPAD) technical advice on vocational training and employment-related issues to MoLSAMD ended in late 2006. However, international agencies and INGO/NGOs continue to extend support to the relevant ministries to develop and deliver vocational training programs for persons with disabilities.

The draft National Law on the Rights and Privileges of Persons with Disabilities includes a provision that at least 3 percent of employees in government offices are persons with disabilities.

The National Labor Strategies, which is also waiting approval by the Lower House, calls for 3 percent of job opportunities and 20 percent of vocational training opportunities be allocated for persons with disabilities.

Persons with disabilities, registered with the MoLSAMD, receive welfare payments of 300-500 Afghanis per month (about 6-10 USD) based on the degree of disability. People registering for pensions are referred to the MoPH for an assessment of the degree of disability. Persons with less than 60 percent disability receive 300 Afghanis per month. No payment is made to people with less than 35 percent disability. It is acknowledged that the allowance is too low to provide a basic standard of living. In 2005, 208,833 people were receiving welfare payments from MoLSAMD; about 50 percent were people with mostly war-related disabilities.

Part 5: Economic reintegration			
Goal: To assist persons with disabilities including landmine survivors to either return to their pre-injury occupation, or prepare for and find suitable employment.	**Objectives @ August 2006:** ▪ Create a directory of all economic reintegration services in Afghanistan, including micro-finance providers, and vocational training and employment centers, by the end of 2006 – **NOT ACHIEVED** ▪ By 2008, national employment agencies will protect, promote and report the number and percentage of persons with disabilities in income-earning employment – **NO REPORTED PROGRESS** ▪ Integrate people with disabilities, including mine survivors, in a package of programs including employment, vocational training, micro-credits, self-employment and other assistance, in the period 2006-2009 – **SOME PROGRESS** ▪ Ensure that at least 30 percent of vulnerable families that include a family member with a disability (or families where the main provider has been killed in a mine/ERW explosion) have access to economic reintegration programs by 2009 – **NO REPORTED PROGRESS** ▪ Improve coordination among relevant actors at the national, regional and local levels by mid-2007 – **NO REPORTED PROGRESS**	**Revised objectives @ April 2008:** 1. Directory of all economic reintegration services in Afghanistan, including micro-finance providers, and vocational training and employment centers, created and disseminated by the end of 2008. 2. The number of people with disabilities, including mine survivors, integrated in a package of programs including employment, vocational training, micro-credits, self-employment and other assistance, increased in the period 2007-2010.	**Actions to achieve objectives:** 1. DSU of MoLSAMD, in collaboration with other relevant actors, will compile all known information of available services into an accessible database, and disseminate and update as required. 2. DSU of MoLSAMD, in collaboration with all INGO/NGOs and organizations working in the field of economic reintegration, will: 2.1 Set up a monitoring, analysis and reporting mechanism to collect information on employment opportunities for people with disabilities in the government and private sector in Kabul by the end of 2008 (expanding to all provinces by 2010). 2.2 Establish a Grant Contract and Management Unit to seek donor funding and to channel existing funds to vocational training and employment support for persons with disabilities by the end of 2008. 2.3 Monitor the inclusion of persons with disabilities, including mine survivors, in the National Skill Development Program and other economic programs within MoLSAMD and other agencies and INGO/NGOs, on an ongoing basis. 2.4 Expand access to interest-free micro-credit for establishing income generating opportunities, on an ongoing basis. 2.5 Encourage affirmative action in the employment of persons with disabilities in all sectors, on an ongoing basis. 2.6 Lobby national employment agencies to protect, promote and report the number and percentage of persons with disabilities in income-earning employment, on an ongoing basis. 2.7 Establish a mechanism to monitor implementation of laws and human rights relating to the employment of persons with disabilities. 2.8 Undertake research on good practice in employment and vocational training for persons with disabilities, on an ongoing basis. 2.9 Develop a strategy to improve accessibility to economic opportunities, including education, vocational training and micro-finance, for persons with disabilities, by 2010.

		3. Ensure that at least 30 percent of families in a vulnerable situation that include a family member with a disability (or families where the main provider has been killed in a mine/ERW explosion) have access to economic reintegration programs by 2010. 4. Coordination among relevant actors at the national, regional and local levels strengthened by 2009.	3. MoLSAMD, in collaboration with other relevant actors, will establish a mechanism to ensure that vulnerable groups have access to programs that promote their economic well-being, by the end of 2008. 4. DSU of MoLSAMD, in collaboration with all stakeholders working in the field of economic reintegration, will: 4.1 Establish an Economic Reintegration Taskforce, which also includes the Ministries of Commerce, Transport, Women's Affairs, and Rural Rehabilitation, with a specific ToR to share good practice and to monitor the inclusion of persons with disabilities in economic reintegration programs, by mid-2008. 4.2 Ensure participation of all relevant actors in taskforce, on an ongoing basis. 4.3 Ensure regular reporting and sharing of resources and expertise, on an ongoing basis. 4.4 Ensure involvement of people with disabilities in the work of the taskforce as much as possible, on an ongoing basis. 4.5 Undertake activities to build the capacity of MoLSAMD to effectively coordinate/monitor/enhance economic reintegration opportunities for persons with disabilities.

Part 6: Community Based Rehabilitation

Status:

During more than 15 years of disability programming in Afghanistan activities have been implemented under the heading of Community Based Rehabilitation (CBR). The programs have mainly been implemented by international NGOs. Because almost no other services were available during the time of civil war, the programs included services such as health care, physical rehabilitation, employment support, preparatory training in sign language, Braille and activities of daily living. Vocational training for young girls and boys was also included.

The CBR programs are still implemented by the INGOS; in addition some national NGOs have started to implement CBR related activities.

INGOs, NGOs and DPOs are cooperating to try out innovative approaches to CBR, with more emphasis on community mobilization and on responsibility by local decision making bodies (shuras). In addition to local Shuras, Community Based Rehabilitation Committees (CBRCs) are one of the supporting groups at community level and are playing a major role in decision making on the rehabilitation of persons with disabilities, introducing community volunteers to the CBR workers, and utilizing local resources for the benefit of persons with disabilities. Also it was decided among the CBR implementers not to have so many parallel groups in the community, instead to support the Community Development Council which is the elected group in the community established by the strongest community development program (NNSP) with representatives of persons with disability. The Disability Department in MoPH is coordinating an informal CBR network.

The Resource Book on Psychosocial Rehabilitation was developed by the Disability Department for implementation by CBR program workers.

CBR programs are implemented in 16 out of 34 provinces (80 out of 364 districts), currently with 22 percent coverage around the country with some differences among the implementing organizations. There is a functioning informal coordination system between CBR implementers and with other development programs at district and community level. CBR implementers visit each others' programs to get new ideas and compare good practices. CBR training including disability awareness is given for health care providers, teachers, and volunteers of various community development programs.

There is a need for more and upgraded training in basic CBR objectives and strategies for CBR program workers, volunteers and representatives in local decision making bodies (Shuras).

The INGO/NGOs who are implementing CBR are presently building up more information and referral systems with health facilities and specialist services such as audiometric services, plastic surgery and orthopedic surgery, governmental schools, and other existing services. But referral systems and the services themselves are still insufficient or lacking.

In February 2006, UNDP contracted a study of CBR, which resulted in the report "CBR in Afghanistan – a report on the current state of CBR in Afghanistan" by Coleridge and Dube. The report emphasized the need for more coordination of CBR programs and more cooperation / integration with general community development programs. Recommendations have been followed up by MoPH and MoLSAMD.

In November 2006 the first national conference on CBR was jointly organized by CBR implementers, other disability stakeholders, the UN and EC, with active participation by MoPH, MoLSAMD, MoT, MoE, members of the Upper House, as well as civil society groups. Based on recommendations from the 2006 conference the informal CBR Network was established in 2007.

Representatives from MoPH and UNDP attended a regional meeting on the development of a regional CBR strategy for WHO's Eastern Mediterranean Region in July 2007. A large delegation from disability NGOs, DPOs, MoPH and UNDP went to the South Asian CBR Network Conference in Nepal in October 2007. At the close of the conference it was decided that Afghanistan will host the next South Asian CBR Network Conference in 2009. One person from the MoPH Disability Department went to the African CBR Network Conference at the end of October 2007.

The MoPH will pilot the regional CBR strategy developed by the WHO. Implementation will start by 2009.

Self-help groups, Disabled Persons Organizations and CBR:

Self-help groups (SHGs) and Disabled Persons Organizations (DPOs) have been facilitated and supported by CBR programs for many years. The structures of DPOs and SHGs could benefit from capacity building and consensus development, in order to become strong advocacy organizations for full participation in the development of all sectors. In general there is a need to increase advocacy skills among people with disabilities and their organizations. At present 29 DPOs throughout Afghanistan are registered at the Ministry of Justice. There is a need to improve coordination and cooperation between SHGs and DPOs at national and sub national levels. Additional work is required for full inclusion of persons with disabilities into developmental programs at all levels. Some DPOs give priority to building up capacity to deliver specific services such as vocational training, literacy courses, awareness- raising and micro-credit programs in some districts that are deemed secure. Others are actively supporting the development of Afghan sign language and supporting the development of material for the sight impaired. (For more information, see the Inclusive Education section.)

Accessibility, free school education and CBR:

There is a lack of access to education services for people with disabilities: CBR programs give preparatory training for seeing, hearing and learning impaired children, in groups or at home. CBR trainers support transition to schools and give awareness training on disability to school teachers. Teachers who show special interest are given supplementary training and some incentives from CBR programs to become support teachers for inclusive education at their schools. Family trainers are also trained by CBR programs to respond to the basic needs of children with disability within the family.

Employment, income generation, community development and CBR:

The CBR programs include some livelihood support, but in general there are limited opportunities for employment of people with disabilities; there are not sufficient training resources. The latest initiatives from CBR in livelihood support are more integrated in local markets and general employment opportunities. The National Solidarity Programme (NSP) is the largest community development program in the country, which supports development of local decision making bodies and local infrastructure through CDCs. People with disabilities are starting to be represented in CDCs; this is mostly promoted by CBR programs.

Women and CBR:

Afghan cultural and religious traditions generally give special attention and respect to women**,** but there is lack of opportunities for women especially for women with disability in all parts of the country particularly in the east and south. There is a general lack of awareness of gender issues throughout the country. In CBR all registration and reporting is split up on basis of gender. Specific concern is given by CBR programs to women and employment support in a culturally acceptable way.

Sports and CBR:

There are organized sport activities at some Community Rehabilitation and Development Centers (CRDCs) run by CBR programs. There are no local sports organizations which include persons with disabilities. Sport for women with disability is partially ignored and there are difficulties for participation in national and international competitions. There is a national Paralympic organization with activities mainly concentrated in Kabul and with weak linkages to districts and provinces and none to CBR. There is also an organization for Special Olympics focusing on mental disabilities, which is also mainly concentrated in Kabul. However, national sports events with participation of people with disabilities from CBR programs in many districts have been organized.

Part 6: Community Based Rehabilitation			
Goal: To assist people with disabilities to fulfill their rights and maximize their physical and mental abilities in order to have full access to all services and opportunities and become active contributors to their community and society.	**Objectives @ August 2006** ▪ Extend functional CBR services according to the basic disability services guidelines, with adequately trained personnel and that are appropriate to the Afghanistan context, to at least 50 additional communities by 2009 – **SOME PROGRESS ON TRAINING COMMUNITY WORKERS**	**Revised objectives @ April 2008:** 1. National CBR strategy developed and approved by the end of 2008. 2. Afghanistan-specific guidelines on good practice to ensure more sustainable and more local based models for CBR work developed by April 2009. 3. National CBR network strengthened during 2008.	**Actions to achieve objectives:** 1. Disability Department of MoPH and CBR implementers will: 1.1 Establish a task force from the CBR network to develop a draft strategy by July 2008. 1.2 Strengthen collaboration on CBR with MoLSAMD during 2008. 1.3 Contract an international expert advisor to assist in development of CBR strategy by September 2008. 1.4 Send draft CBR strategy for comment to relevant Ministries, NGOs and Civil society organizations. 1.5 Get final approval of draft CBR strategy among the stakeholders by the end of 2008. 2. Disability Department of MoPH and CBR implementers will: 2.1 Coordinate visits between CBR programs to compare experiences and analyze the situation to determine the needs of people with disabilities, their families and assess availability of the resources that can improve the situation of people with disabilities. 2.2 Follow up and document experiences from cooperation and handing over to local NGOs, DPOs and shuras. 2.3 Implement a needs assessment for CBR training of staff and volunteers by October 2008. 2.4 Develop new CBR training programs for staff, local volunteers, decision makers and DPO/CBO members based on recommendations from the assessment. 2.5 Convene a minimum of 3 pilot trainings by April 2009. 2.6 Draft Afghanistan-specific guidelines on good practice in CBR using tools developed by WHO and South Asian CBR network. 3. Disability Department of MOPH and the CBR network will: 3.1 Arrange regular national and regional meetings with focus on exchange of experiences from CBR program development and training. 3.2 Convene a national CBR network conference in November 2008.

			3.3 Convene a regional South Asian CBR network conference in 2009.
		4. Coverage of CBR programs expanded to 20 new districts and 4 new provinces by the end of 2009.	4. Disability Department of MoPH will facilitate CBR implementing partners to: 4.1 Establish pilot programs in 10 new districts in 2008, focusing on areas without services such as central Afghanistan. 4.2 Establish pilot programs in 10 new districts in 2009.
		5. Capacity of at least 10 DPOs strengthened by the end of 2008.	5. Disability Department of MoPH and MoLSAMD will facilitate CBR implementing partners to: 5.1 Provide advocacy training to 10 DPOs in 2008. 5.2 Provide planning and management training to 10 DPOs in 2008. 5.3 Support DPOs in local advocacy and information campaigns. 5.4 Facilitate DPO representation in local shuras and CDCs.
		6. Awareness in the community about the rights and situation of persons with disabilities, raised on an ongoing basis.	6. Disability Department of MoPH and DSU of MoLSAMD, in collaboration with CBR implementing partners will: 6.1 Undertake information campaigns to local communities and districts. 6.2 Share information through local cooperation with stakeholders in all sectors. 6.3 Document experiences on awareness campaigns from 10 provinces by first quarter of 2009.

Part 7: Inclusive Education

Status:

In Afghanistan, the right to education for all children is supported by the Ministry of Education's National Education Strategic Plan for Afghanistan 1385-1389 (2006-2010) and is consistent with the Afghanistan Constitution and Afghanistan National Development Strategy (ANDS). The Afghanistan Millennium Development Goals state that "by 2020, children everywhere, boys and girls alike, will be able to complete a full course of primary school".

The National Disability Survey in Afghanistan (NDSA) found access to public education is significantly different for persons with disabilities and persons without disabilities. Almost 73 percent of persons with disabilities above 6 years of age did not receive any education, whereas the rate is 51.4 percent for people without disability. A crucial aspect that influences access to education is the age at which a person became disabled. Having a disability before access to school age strongly influences access to any form of education. The NDSA confirms that girls have less access to school than boys. Only 15 percent of girls with a disability before age 7 go to school compared to 24 percent for girls without disability. Urban centers are providing easier access to schools for children than in the past and males have better access to education in all regional areas. Children with disabilities have less access than children without disabilities. Retention and completion for children with disabilities is statistically significant between persons who became disabled at an early age (before 7 years) and people disabled after school-starting age.

A Special Education Faculty was established in 2004 within the University consisting of four departments: visual impairment; hearing impairment; physical disability; and mental disability. Currently this faculty has around 90 students with four teachers.

The MoE's 5-year National Education Strategic Plan (NESP) states that "As new educational facilities are constructed, the needs of children with disabilities will also be considered in order to increase their access to education. Where possible, children with disabilities will be integrated into regular schools which could require some building modifications, special training for teachers and appropriate curriculum considerations. Where indicated by need, provincial resource centers will be established and equipped to serve children with hearing, visual and multiple impairments. As much as possible, these centers will prepare children to access regular schools and will also provide some additional specialized classes or tutoring where appropriate. Teachers with special training to teach children with disabilities will be recruited to work in these schools/resource centers….The target is to attain a net primary school enrolment rate for children with disabilities of 45% for boys and 30% for girls by 1389 (2010)."

The NESP includes six main objectives relating to the education of children with disabilities: Develop policies and guidelines for education of children with disabilities; Establish a coordination body for education of children with disabilities; Adapt, as necessary, the basic education (grade 1-9) curriculum to meet the needs of children with disabilities and develop special teaching and learning materials; Establish and equip special schools/resource centers for children with disabilities; Recruit/assign sufficient qualified teachers to teach children with disabilities (one coordinator, 8 qualified teachers and 5 support staff for each provincial resource center (95 over 4 years); and, Facilitate integration of children with disabilities into regular schools.

A Department of Inclusive Education was established at the MoE in late 2006. This Department coordinates and implements pilot programs for the Ministry and is allocating 34 staff responsible for inclusive education in 34 provinces. The pilot project will expand into 5 provinces, 3 schools in each province for a total of 15 schools during 2008. A total of 25 resource persons for training will be hired by UNICEF; 5 persons in 5 province during 2008.

The MoE initiated an inclusive education pilot project in Kabul in 2007 in three schools; 30 teachers were trained in inclusive education and 60 parents. Thirty-two children with different types of disabilities were enrolled in the program. An awareness campaign was initiated with staff and children at the inclusive schools in Kabul which built positive attitudes and acceptance, involving 30,000 persons.

CBR and other programs run by INGO/NGOs have provided preparatory training for sight, hearing, mobility and learning impaired children, and the building of ramps to improve accessibility, for more than ten years. The programs have facilitated inclusion of children with disabilities into local schools. Special education programs are being implemented by international agencies and INGOs/NGOs in 16 provinces: Badakhshan, Baghlan, Balkh, Ghazni, Herat, Jowzjan, Kabul, Kandahar, Kunduz, Laghman, Logar, Nangarhar, Parwan, Samangan, Takhar and Wardak.

The five special education schools in Herat, Jalalabad, Kabul, Kandahar and Mazar-i-Sherif will serve more as resource centers in the future.

The main stakeholders in Afghanistan in inclusive and exclusive/special education include the MoE, the MoLSAMD, UNICEF, UNESCO and other UN agencies, other international agencies and several INGO/NGOs and DPOs.

Part 7: Inclusive education			
Goal: To assist children, youths and adults with disabilities, including mine survivors, to access and remain in education based on their individual level of need.	**Objectives @ August 2006:** ▪ Develop a comprehensive plan for inclusive and exclusive education for children with disabilities by 2008 – **DEPARTMENT OF SPECIAL EDUCATION ESTABLISHED IN MoE** ▪ Ensure that all new school buildings and at least ten percent of existing schools per year are made physically accessible to children with disabilities – **SOME PROGRESS** ▪ Conduct awareness-raising activities in schools for teachers and students on the rights and capacities of children with disabilities – **SOME PROGRESS** ▪ Develop the curriculum for primary level inclusive and exclusive education by 2008 – **DEPARTMENT FOR SPECIAL EDUCATION ESTABLISHED IN MoE** ▪ Establish a teacher training program for inclusive and exclusive primary education by 2008 – **SOME PROGRESS IN KABUL**	**Revised objectives @ April 2008:** 1. All key stakeholders will have an increased awareness of the concept of inclusive education, particularly at the policy level, by the end of 2008. 2. Pilot project in Kabul City on Inclusive Education implemented by the end of 2008 and expanded access to education into other areas by 2010. 3. Standard tools and pedagogical materials for inclusive education in Afghanistan developed and disseminated by 2010.	**Actions to achieve revised objectives:** 1. Department of Special Education (DSE) of MoE, in collaboration with relevant stakeholders, will: 1.1. Map out national status and trends on inclusive education, and identify gaps and priority areas for advocacy with support from UNESCO by the end of 2008. 1.2. Develop an advocacy strategy, with support from UNESCO and disseminate by end of 2008. 1.3. Widely share concepts and practices on Inclusive Education among the MoE staff members and school teachers through an advocacy seminar convened with support from UNESCO and MACA by the end of 2008. 2. DSE of MoE, in collaboration with UNICEF, UNESCO, UNDP, MACA and relevant INGO/NGOs, will: 2.1 Conduct training for 100 teachers, 12 principals of schools, and 200 parents of children with disabilities in Kabul City in 2008. 2.2 Conduct training for 150 teachers, 15 principals of schools, 10 provincial directors, and 300 parents of children with disabilities in selected regions of the country in 2008. 2.3 Conduct training for 640 teachers for 2 days on awareness of special and inclusive education and 90 teachers for one week on introduction to Braille, sign language and teaching of mentally impaired. 2.4 Improve school access through the inclusion of 100 children with disabilities at pilot schools in Kabul City during 2008. 2.5 Improve school access through the inclusion of 150 children with disabilities in at least 19 pilot schools in other regions of Afghanistan by 2010. 3. DSE of MoE, in collaboration with UNESCO, UNICEF, and relevant INGO/NGOs will: 3.1 Develop and disseminate a standardized tool kit on inclusive learning friendly environments by 2009.

			3.2 Develop guidelines for tools, materials and methodology for teachers and parents for inclusive education by 2010. 3.3 Make available accessible formats for children with sensorial impairments by 2009.
		4. Institutional capacity built at all levels to improve access to learning friendly environments and to expand inclusive education by 2009.	4. DSE of MoE, in collaboration with UNICEF, UNESCO and other relevant stakeholders will: 4.1 Train resource persons on inclusive education including 10 master trainers in Kabul Province and 28 resource persons in four selected provinces by 2009. 4.2 Train school teachers and principals on inclusive education approaches in at least 10 selected provinces in Afghanistan by 2009. 4.3 Conduct training for 80 master trainers, 665 trainers and 10,000 teachers under UNICEF's Healthy School Initiative Program (HSI) by 2009.
		5. Awareness-raising conducted and families and communities trained in inclusive concepts in educational settings by 2009.	5. DSE of MoE, in collaboration with UNICEF and other relevant stakeholders will: 5.1 Conduct advocacy training for 120 family members of children with sensorial impairments and physical disabilities in school by 2009. 5.2 Conduct orientation training on UNICEF's HSI Program for 10,000 members of Parent Teacher Associations and 136 children's clubs established in HSI schools by 2009.
		6. Increase access to schools through the improvement and flexibility of the learning environment at school by 2010.	6. DSE of MoE, in collaboration with other relevant ministries and stakeholders, will work to ensure that appropriate accessibility aids for girls and boys with disabilities are provided in school buildings, classrooms and toilets. 6.1 All new school buildings and at least two percent of existing schools per year will be made physically accessible by 2010.
		7. Net primary school enrolment rate for children with disabilities of 45 percent for boys and 30 percent for girls attained by 2010.	7. DSE of MoE, in collaboration with other relevant stakeholders, will fully implement the special program and activities relating to children with disabilities under the NESP during the period to 2010.

Part 8: Laws and public policies

Status:

The Constitution of Afghanistan guarantees the rights of persons with disabilities, especially under Article 53 and 84, and with a general reference in Article 22. The Ministry of Labor, Social Affairs, Martyrs and Disabled (MoLSAMD) is the ministry and focal point responsible for all issues relating to persons with disabilities, including mine survivors. The MoLSAMD has a presence in all 34 provinces. MoLSAMD's objectives for the disability sector include: collecting data on persons with disabilities from all provinces to facilitate access to monthly pensions; advocating for the rights of persons with disabilities; development of new legislation to protect the rights of persons with disabilities; facilitating access to vocational training courses; and, the inclusion of persons with disabilities.

Disability is a multi-sectoral issue with the following ministries and independent directorates currently involved: Ministry of Public Health (MoPH), Ministry of Education (MoE), Ministry of Women's Affairs (MoWA), Ministry of Rural Rehabilitation and Development (MoRRD), Ministry of Finance (MoF), Ministry of Culture and Information (MoCI), Ministry of Justice (MoJ), Ministry of Foreign Affairs (MoFA), Ministry of Transportation and Civil Aviation (MoTCA), Ministry of Religious Affairs and Pilgrimage (MoRAP), Ministry of Urban Development (MoUD), Office of President, Afghan Independent Human Rights Commission (AIHRC), Civil Society Forum, and the Parliament.

MoLSAMD, with support from civil society in line with the Afghanistan Constitution and international conventions, prepared the "National Law for the Rights and Privileges of Persons with Disabilities." This law was submitted to the President's Administrative Office who then forwarded the draft law to Cabinet. The draft law was reviewed by the Ministry of Justice and approved by Cabinet in late 2007 and it is presently under discussion in the Lower House.

The disability movement in Afghanistan is still in its infancy. Illiteracy and extreme poverty, limited exposure and inadequate skills in institutional development are some of the problems faced by the movement. As a result the voice of persons with disabilities and their capacity to negotiate on behalf of their own interests in planning and decision-making is lacking and should be strengthened. The movement is also challenged by negative attitudes in society, physical and legal barriers and access issues.

There is no standard terminology to describe different types of disabilities, levels of need and related terms in Afghanistan. Different names are being used for persons with disabilities that are sometimes discriminatory or demeaning.

Afghanistan continues to debate the signing of the UN Convention on Rights of Persons with Disabilities (CRPD), though there is pressure from civil society to sign and ratify it. Afghanistan was engaged in the Ad Hoc meetings and negotiations on the CRPD.

Afghanistan is a signatory to the Declaration on the Full Participation and Equality of People with Disabilities in the Asia Pacific Region, and a signatory to the Biwako Millennium Framework for action towards an inclusive, barrier free and rights based society for persons with disability. Afghanistan also recognizes the World Program of Action, the Standard Rules on the Equalization of Opportunities for Persons with Disabilities, and the 1983 International Labor Organization Convention 159 on Vocational Rehabilitation and Employment (Disabled Persons).

The planned 2008 National Census questionnaire has one question with five components on households with a family member with a disability. In 2005, the National Disability Survey in Afghanistan was conducted which provided prevalence rates, statistical analysis and comprehensive information on the situation of persons with disabilities in Afghanistan with accompanying recommendations.

Disability and particularly physical rehabilitation is recognized as a priority of the MoPH and become part of the two strategies of the MoPH; the BPHS (Basic Package of Health Services) and EPHS (Essential Package of Hospital Services). In addition, the issue of education for children with disability is reflected in the 5-year National Education Strategic Plan (2006-2010) of the MoE.

Afghanistan underwent an extensive inter-ministerial process to develop the Afghanistan National Development Strategy (ANDS) for 2005-2009. It includes mine action and disability issues. ANDS states that by the end of 2010 (1389), "increased assistance will be provided to meet the special needs of all disabled people, including their integration in society through opportunities for education and gainful employment."

In 2003, Afghanistan developed a Comprehensive Disability Policy through extensive consultations with relevant actors and line Ministries. Throughout 2004 the former Ministry of Martyrs and Disabled (MMD – now part of MoLSAMD) and all stakeholders also worked on a project to establish a National Disability Commission; an inter-ministerial administrative body aimed at enabling a more effective approach to disability. The process of final approval by the Government was not completed. In May 2005, the former MMD began a consultative process to develop a new three-year National Framework for Action on Disability 1385-1388 (2006-2008) in Afghanistan, which was finalized in early 2006. The framework was developed in close consultation with some relevant line Ministries with technical support from United Nations Development Program (UNDP) through the National Program for Action on Disability (NPAD). However, after sector consultation this activity appears to have been premature and did meet needs of the Ministry. NPAD ceased activities in early 2008.

In August 2006, the First National Victim Assistance Workshop was held in Kabul. The aim of the workshop was to develop a plan of action that would not only meet Afghanistan's obligations under the Anti-Personnel Mine Ban Convention but also serves as an important step in developing a comprehensive plan for all persons with disabilities through the establishment of an inter-ministerial coordination group. Some of the objectives from the plan of action were included in the ANDS. This current document reflects a review of that plan of action.

Almost all disability services are currently provided by national and international NGOs and agencies. The government's role in service delivery to persons with disability is minimal. The Government of Afghanistan recognizes that policy implementation should be done in partnership with other key actors working at the grass roots level. In 2005, MMD established an NGO coordination unit, which was intended to assist in the coordination of non governmental actors in the disability sector. In 2006, the MoPH established a Disability Taskforce with the aim of improving coordination and cooperation between all actors in the disability sector.

In 2007, MACA supported by the United Nations signed a Memorandum of Understanding with the Government of Afghanistan to provide technical support to build the capacity of the Government on the disability issue and to develop systems for mainstreaming disability issues. Based on this MoU, the Disability Support Unit (DSU) was established in MoLSAMD under the direct supervision of the Deputy Minister of MoLSAMD for disability issues. The DSU will assist in developing implementation strategies, work plans and monitoring mechanisms, with the aim of achieving the disability-related benchmarks under the ANDS and addressing obligations to mine survivors and other persons with disabilities under the AP Mine Ban Convention, with the ultimate aim of improving the quality of life of persons with disabilities in Afghanistan. In addition to building the institutional capacity of the MoLSAMD, the DSU will facilitate the establishment of an inter-ministerial coordination mechanism to enhance the delivery of disability-related services in Afghanistan. NGO coordination meetings will be conducted under the umbrella of the DSU through the Disability Stakeholders Coordination Group (DCG). The DSU has also assisted in the development of an Advocacy Action Plan for 2008-2010 to help the MoLSAMD achieve the goals of the ANDAP.

Part 8: Laws and public policies			
Goal: To establish, implement and enforce laws and public policies that guarantee the rights of landmine survivors and other persons with disabilities	**Objectives @ August 2006:** ▪ Disability focal points in at least 4 key ministries by early 2007 – **ACHIEVED IN 3 MINISTRIES** ▪ Adopt a three-year national framework for action on disability in 2006 – **NOT ACHIEVED** ▪ Conduct a nation-wide awareness raising campaign on disability issues in 2007 and beyond, which includes raising awareness on the rights and capacities of persons with disabilities – **ACTIVITIES IMPLEMENTED AND ONGOING** ▪ Develop, adopt and implement a National Disability Policy by 2008 – **NO PROGRESS** ▪ Draft and adopt a comprehensive law for persons with disabilities that guarantees their rights to medical care, rehabilitation, education, employment, social services, and an accessible and barrier free society free from discrimination, with due importance given to the rights of women with disabilities, by the end of 2007 – **DRAFT LEGISLATION BEFORE PARLIAMENT** ▪ Ratify the 1983 International Labor Organization Convention 159 on Vocational Rehabilitation and Employment (Disabled Persons) by 2008 – **NOT ACHIEVED** ▪ Sign and ratify the international	**Revised objectives @ April 2008:** 1. National Law for the Rights and Privileges of Persons with Disabilities, adopted and implementation started by the end of 2008. 2. Convention on the Rights of Persons with Disabilities (CRPD), signed, ratified and implementation stated, by the end of 2008. 3. Appropriate Afghanistan-specific disability terminology developed and disseminated by 2009. 4. 1983 International Labor Organization Convention 159 on Vocational Rehabilitation and Employment (Disabled Persons) ratified by 2009. 5. Implementation of disability-related benchmarks in the Afghanistan National Development Strategy and the objectives of the Afghanistan National Disability	**Actions to achieve revised objectives:** 1. DSU of MoLSAMD and civil society groups including Afghanistan Independent Human Rights Commission will: 1.1 Lobby the Disability Committee in the Lower House and representatives of persons with disabilities in the Upper House for early adoption of the new legislation by mid 2008. 1.2 Establish a committee to observe the implementation of the National Law for the Rights and Privileges of Persons with Disabilities, in 2008. 2. DSU of MoLSAMD, in collaboration with civil society will: 2.1 Lobby the government to sign and ratify the CRPD in 2008. 2.2 Raise public awareness within the public through a campaign using radio, television, print media, workshops, and a mobile theater to lobby the government to sign and ratify the CRPD in 2008. 2.3 Provide training to DPOs and other civil society groups on the CRPD in 2008. 2.4 Establish a committee to observe the implementation of the CRPD, by 2009. 3. DSU of MoLSAMD, in collaboration with relevant stakeholders, will: 3.1 Create a dictionary of appropriate disability-related terminology, by the end of 2008. 3.2 Disseminate the dictionary to a wide audience including ministries, radio, television, print media, international agencies, INGO/NGOs schools, and the public, by 2009. 4. DSU of MoLSAMD, in collaboration with civil society will lobby the government to sign and ratify the Convention by 2009. 5. DSU of MoLSAMD will establish a mechanism to collect information to monitor progress in implementing disability-related activities under the ANDS and ANDAP, on an ongoing basis.

	convention on the rights of persons with disabilities and launch an awareness-raising campaign in all major cities – **DISCUSSIONS UNDERWAY** ▪ Develop and disseminate an up-to-date directory of all NGOs/agencies working in the disability sector indicating their place of work, functions, funding sources, and priority areas by the end of 2006 – **DRAFT DEVELOPED BUT NEEDS TO BE IMPROVED** ▪ Develop and strengthen national Disabled Person's Organizations (DPOs), on an ongoing basis – **ACTIVITIES UNDERWAY AND ONGOING** ▪ Establish disability resource centers in the eight regions of Afghanistan by 2008 – **ACTIVITIES UNDERWAY AND ONGOING (4 CENTERS CONSTRUCTED)** ▪ Establish a data bank of quality research and Afghanistan-specific information by 2008 – **SOME PROGRESS** ▪ Improve accessibility to all government buildings by 2009 – **SOME PROGRESS IN SCHOOLS** ▪ Raise the priority given to disability issues within relevant government ministries by the end of 2006 – **SOME PROGRESS WITH THE CREATION OF DISABILITY UNITS/ DEPARTMENTS**	Action Plan (ANDAP), monitored on an ongoing basis. 6. A nation-wide awareness raising campaign on disability issues conducted in 2008 and beyond, which includes raising awareness on the rights and capacities of persons with disabilities. 7. National Disability Policy developed by 2010. 8. An up-to-date directory of all NGOs/agencies working in the disability sector, or on disability-related issues, developed and disseminated by the end of 2008. 9. National Disabled Person's Organizations (DPOs), developed and strengthened on an ongoing basis. 10. Disability resource centers established in the eight regions of Afghanistan by 2009. 11. Accessibility to buildings and disability-related services improved by 2010.	6. DSU of MoLSAMD, in collaboration with other relevant actors, will develop and coordinate a campaign using radio, television, print media, workshops, and a mobile theatre, on an ongoing basis. 7. DSU of MoLSAMD, in collaboration with relevant ministries and national and international organizations, will: 7.1 Recruit a technical advisor to assist in the process of developing a comprehensive disability policy, by 2009. 7.2 Establish a taskforce by 2009 to elaborate a comprehensive policy. 8. DSU of MoLSAMD will compile and disseminate all known information on organizations working in the disability sector, or on disability-related issues, and request new information as needed, to create an accessible database for distribution to all relevant ministries and agencies, by the end of 2008. 9. DSU of MoLSAMD, in collaboration with all relevant stakeholders including the Independent Commission for Human Rights, Afghan Civil Society Forum, and UN and international agencies, will implement a program of training and capacity building for national DPOs. 10. DSU of MoLSAMD, in collaboration with other relevant stakeholders, will develop accessible centers to house information on disability issues, and equipment and other facilities for use by people with disabilities, and produce newsletters on key issues. 11. DSU of MoLSAMD, in collaboration with other relevant stakeholders and design experts, will document problems in accessibility to buildings and services, and develop and implement a plan to overcome the problems, by 2010.

	▪ Establish a Disability Coordination Body by 2008 to coordinate, monitor and report on activities of all stakeholders – **SOME PROGRESS WITH ESTABLISHING COORDINATION MECHANISMS IN 2 MINISTRIES** ▪ Disability-related benchmarks are articulated in the Afghanistan National Development Strategy by the end of 2006 – **ACHIEVED**	12. Disability maintained as a priority issue within relevant government ministries on an ongoing basis.	12. DSU of MoLSAMD, in collaboration with relevant ministries and other stakeholders, will: 12.1 Bring together all existing disability structures within relevant ministries to improve coordination, monitoring, and reporting on national disability-focused plans and programs, on an ongoing basis. 12.2 Strengthen inter-ministerial coordination and collaboration on the disability issue, on an ongoing basis. 12.3 Create a mechanism to collect information and report on activities in the disability sector, on a regular basis, to improve planning and decision making at the national, regional and local levels, to avoid duplication in the delivery of disability services, by mid-2008. 12.4 Identify gaps in statistical, academic and action research to inform disability policy by the end of 2008. 12.5 Promote relevant gender specific data collection and research, on an ongoing basis 12.6 Promote scholarships for disability studies including capacity building of in-country researchers, on an on-going basis. 12.7 Establish a database of multi-sector research to support national mainstreaming of disability issues, on an ongoing basis.