Transforming Development Beyond Transition in Afghanistan:
Service Delivery Position Paper

"Based on the high rate of illiteracy, particularly among Afghan women, having a functional and quality education system is vital."
Najia Anwari, Programme Manager, Coordination for Humanitarian Assistance

Overview

This paper is one of a series highlighting civil society actors' concerns in the lead up to the 2014 London Conference on the Tokyo Mutual Accountability Framework (TMAF). Other papers in the series focus on aid effectiveness, governance and women's rights.

The lack of reliable, extensive and comparable data is an issue affecting developing countries, in particular Afghanistan and its most isolated and conflict-impacted areas. This heavily affects the analysis of the service delivery sector and complicates proper and systematic analysis on progress, the remaining gaps and needs. However ACBAR members have used their extensive knowledge of Afghanistan and long-term field experience to develop the following analysis and recommendations.

Progress since 2012

In the past decade, significant progress has been made in Afghanistan in terms of delivering services to the population, in particular health and education. According to the Ministry of Public Health (MoPH), 9 per cent of the population was living in districts where health facilities were accessible in 2001, compared to 86.7 per cent in 2011.[1] Knowledge and acceptance of health practices by communities has also improved greatly. Basic understanding of hygiene practices, the need for vaccinations, specific care for mothers and newborn infants, and reproductive healthcare is more widespread. This can be partially attributed to community-based approaches to health combined with better communication and awareness projects, as well as increased recruitment and training of female health workers. As a result, various health indicators have improved. The maternal mortality rate reduced dramatically from 1,000 deaths per 100,000 live births in 2000[2] to 327 in 2013.[3] Under-five mortality rates reduced from 131 deaths in every 1,000 live births in 2001, to 91 in 2011–12.[4] Life expectancy went from 44.5 years at birth in 2001[5] to 62–64 years in 2010.[6] These improvements are also the result of a proactive national public health policy, implemented by the MoPH, which in most of the provinces contracts out the implementation of its Basic Package of Health Services and its Essential Package of Hospital Services (BPHS/EPHS) to competent non-government organisations (NGOs) who deliver the services to communities.

In education, there has been great improvement in terms of available infrastructure and numbers of trained teachers and students benefiting from public primary education. The number of teachers rose from 20,000 before 2001 to more than 172,000 in 2012 (31 per cent of whom are female).[7] In 2013, 15,169 schools existed, of which 2,267 were dedicated to girls[8] and more than 8.6 million students attended these schools.[9] Indeed the net enrolment ratio for 2008–2012 in primary school rose to 63 per cent for boys and 46 per cent for girls.[10] This compares to 2001 when only 900,000 children nationally had access to school, representing 38 per cent of boys and only 3 per cent of girls in the country.[11] Adult literacy levels have improved: they were at 45 per cent for men in 2012, but 17 per cent for women. On average this represents 31 per cent, compared to 26 per cent in 2007–8.[12] Vocational training is now more available. Finally, support to students accessing higher education has also improved through mentoring

classes or scholarships, allowing marginalized students (girls and women, from remote areas, from extremely poor families, etc.) to access high schools and universities.

Challenges

However, despite major improvements and progress, many Afghans do not benefit from existing services whatever their quality. Outside the main urban areas, millions of Afghans still struggle to access basic healthcare – for example, 18,000 Afghan women die in childbirth annually,[13] one of the highest maternal mortality rates in the world. Many Afghans cannot provide a quality formal education for their children; 68 per cent of pupils leave school before finishing grade 6, the end of primary school[14] and nearly 20 per cent of the total number of children enrolled in school are permanently absent.[15] In cities, the availability of services for fast-growing populations remains a challenge, in particular for marginalized communities.

Furthermore, official figures report the theoretical number of people who have access to facilities, based on the number of people living in a specific area. They do not use the number of people who actually access and benefit from these services, which is often much lower. In addition, the extreme reliance of the Afghan government on international funding (85 per cent of the Afghan Public Budget comes from abroad) creates major concerns regarding the sustainability of these services to the population.[16] ACBAR members have identified the following main challenges.

Problems of access: The International Committee of the Red Cross (ICRC) estimated in 2009 that more than half of the population had little or no access to basic services, including healthcare services.[17] These difficulties of access result from several factors. A major factor is the continuing high levels of insecurity. This results from both the ongoing armed conflict between armed opposition groups and the pro-government forces – with an ever-increasing impact on the civilian population from 2009 onwards[18] – and from growing levels of criminality. To differing extents across the country, insecurity hampers service delivery directly (through closure, occupation, suspension, delay in accessing services, populations avoiding movement, etc.)[19]; as well as indirectly, where it aggravates other barriers to proper service delivery.

When people and staff perceive services as not being secure, this can have a long-lasting impact. In 2012, 450 health facilities closed – temporarily or permanently – for insecurity reasons, up by 40 per cent compared to 2011.[20] Such constraints on service providers and service users greatly reduce the actual reach of existing services, and can be life-threatening in the case of health emergencies. Violence against health facilities violates the Geneva Conventions and the Additional Protocols,[21] while attacks and incidents against schools (167 reported in 2012[22]) are recognized internationally as a violation of children's rights.

Another key factor limiting access is gender inequality. This restricts or sometimes simply prevents women and girls from accessing services, especially when female professionals are not available, or are unable to work in the most violent areas. Other factors include: the irrational and non-needs-based repartition of services across districts and provinces, sometimes due to corruption; the overall level of poverty among the population, often unable to pay for the cost of transportation to facilities or other indirect service costs; the unavailability or low quality of transportation infrastructures which increase travelling time; the lack of financial resources available; and finally the difficult terrain of Afghanistan, especially during winter and for extremely remote communities.

Poor quality of services: The services that exist are also not always properly functioning and their quality is often questionable due to many reasons. For example human resources issues, both quantitative and qualitative, impede delivery of quality services. This especially concerns female professionals who are affected by both cultural practices and high levels of violence. In the health and education sectors, the overall number of skilled professionals is too low to meet the need of the growing population; there are not enough staff nor is training adequate, either initially or on a continuous basis. The geographical spread of staff is also uneven and problematic, as many are concentrated in urban areas for reasons related to insecurity or financial interest. The inability of service providers to recruit appropriate staff results in lower quality services, especially in the rural areas.

In education, classes are organized in three or four shifts per day, to maximize the number of students attending classes, which are delivered by too few teachers. As a result, the number of school hours per child is too low and the numbers dropping out increase. Training and availability of teachers is also limited, especially at the secondary level.[23] In health, Afghans frequently report low levels of trust in the skills of medical personnel, resulting in greater preference for the private health sector which is much more costly. This has an important impact on the poorest families, who are forced to incur debts, delay, or simply decide not to receive care.[24]

Corruption and poor management also contribute to the low quality of services. Infrastructure and operating materials/ supplies are also often lacking, inappropriate or in poor condition. There are still too few school buildings many of which are in poor conditions; textbooks that are supposed to be freely available often are not. Teachers, whose pay levels are too low, often have other jobs to boost their income, and are not always teaching the amount of hours that they should. In clinics, opening hours are often too few and facilities sometimes close without warning; doctors sometimes run their private practice during their official clinic time. Drugs and other essential medical devices are sometimes unavailable; or being sold contrary to the guidelines. Their quality is perceived to be poor by the population, with even instances of fake drugs reported.[25]

Additional factors include policy design and implementation of national systems that are not fit for purpose, combined with financial problems. Guidelines, methodologies and policies that are not harmonized create confusion at field level and cause inequalities across areas. Bureaucratic processes in government prevent timely payments of invoices and slow down delivery. Inappropriate funding levels and mechanisms (in particular financial tracking) also prevent proper implementation according to guidelines. Finally, the lack of appropriate monitoring and evaluation of the actual delivery of services prevents authorities from adopting suitable measures to tackle the problems. For example, in the education sector, there are reports of inconsistent curriculums, inadequate complaints mechanisms, and delayed payments to teachers. In health, entire components of the BPHS/EPHS policies are not systematically implemented because the selection process for implementers focuses too heavily on costs and does not take into account quality criteria. As a result, medical specialties such as physical rehabilitation, mental health, nutrition, trauma and emergency care, and maternal and neo-natal health are lacking.

Awareness and inclusion: Despite major progress, levels of awareness among the population remain a concern. Indeed lack of knowledge and understanding of the need, use and availability of services reduces the potential positive impact that these services could have on the lives of the population. Sanitation and hygiene practices still need to be better understood and used; as does the importance of family planning, of proper food security at household levels, the need for close follow-up of pregnant women and newborn infants and the role of physical rehabilitation.

This is particularly the case for the most vulnerable and marginalized groups such as nomadic communities, people with disabilities, isolated minors, internally displaced persons and returnees, illiterate and excluded villagers, women, and ethnic minorities, who are often discriminated against and excluded from their communities and development programmes. They are also left out by many services, across all sectors, deliberately not targeted by implementers who fear higher costs and who lack technical expertise or they are forgotten due to improper policy implementation. As a result, they experience even less access to services compared to the overall population, perpetuating their marginalization and vulnerability.

Recommendations

The international community should:

- Commit to sufficient long-term funding, in particular in health, education and rural development, to ensure that progress made most recently is sustained and enhanced in the future. Programming should be focused on meeting the current gaps and improving the overall quality of services, based only on the needs of the local population, and not working to a military and political agenda.

The Afghan government should:

- Focus on the overall quality of services by improving service delivery systems and policy implementation in the field. Specifically it should:
  - increase the number of services available in under-served areas to ensure adequate availability of services as per guidelines and international recommendations;
  - update and harmonize policies to tackle on-the-ground difficulties;
  - ensure allocation of appropriate levels of funding for programme implementation, targeting quality of services and availability of supplies.
- Develop a realistic plan to improve human resources (quality, availability, needs-based, properly trained to deliver quality services, including for female staff and in rural/remote areas), resulting in improved coverage of services throughout the country, as per the needs of the population.
- Develop better monitoring and evaluation processes to collect proper data on services effectively delivered (and not the theoretical number of facilities available) and on existing gaps in meeting the needs of the whole population, including the most marginalized.

The Afghan government and the international community should:

- Focus on improving service delivery to the most contested and violent areas, where populations are disproportionately suffering from inadequate service provision. They should both:
  - Acknowledge the existence of humanitarian needs and support independent funding mechanisms and practical delivery of humanitarian aid to answer these needs, in particular for populations living in conflict zones. Ensure that such aid is delivered independently of political and military agendas.
  - Ensure that education and health facilities and staff are respected, in particular by armed forces and political actors. The neutrality of these services needs to be protected as per international humanitarian and human rights laws.

- Ensure that financed and implemented services include the most marginalized and vulnerable groups to ensure a more inclusive development of Afghanistan.

- Ensure that, when situations allow, projects are long-term based and sustainable, preferably using community-based approaches and support to civil society, in order to be more inclusive of the opinions and needs expressed by the population itself. This will maximize long-term impact, acceptance, and will support the development of an open and dynamic society.

- Support livelihoods which is at the core of rural development activities, in particular through income-generating activities, increased access to credit and provision of technical expertise, in order to tackle poverty at its source and improve resilience of the most vulnerable, such as small and poor farmers.

Endnotes

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Image: Fresh water arrives in a rural village in Afghanistan

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