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Intersecting Crises, Unseen Strength: Persons with Disabilities Shaping Their Future in Afghanistan

Presented by Orzala Nemat and Shukria Azadmansih, with Fellows from Afghanistan.

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TARIN KOT, ORUZGAN — 35-year-old former Afghan policeman Abdul Nafi poses with his children in Tarin Kot, the capital of Afghanistan's Oruzgan province. According to the UN, 80% of Afghan adults live with some form of disability. Photo: ©Baryalai Ansari

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The research draws on the knowledge, dedication and lived experience of local researchers and collaborators across different regions of the country. Their contributions were central to the design, data collection, analysis and overall development of this report. However, in light of the current security environment and to mitigate potential risks, these individuals cannot be formally named.

About the Authors

This report was prepared by a team of local researchers, including some members of disability-led organisations in Afghanistan, in collaboration with DRG, under the leadership of Dr Orzala Nemat, a scholar and expert on Afghanistan with extensive experience in research, policy and development practice, and Ms Shukria Azadmansih as her assistant.

DRG extends its sincere appreciation to all contributors whose efforts made this study possible. At the same time, DRG assumes full responsibility for any errors, omissions, or shortcomings in the report.

Acronyms

AFN: Afghani (Afghanistan currency)

ANOD: Afghanistan National Organisation of the Deaf

CEDAW: UN Committee on the Elimination of Discrimination against Women

CRC: UN Convention on the Rights of the Child

CRPD: UN Convention on the Rights of Persons with Disabilities

CSO: Civil society organisation

DRG: The Development Research Group Ltd

HI: Handicap International

HRW: Human Rights Watch

IASC: Inter-Agency Standing Committee

ICF: International Classification of Functioning, Disability and Health

ICRC: International Committee of the Red Cross

ICT: Information and communication technology

ICESCR: UN International Covenant on Economic, Social and Cultural Rights

ILO: International Labour Organization

INGO: International non-governmental organisation

MDS: Model Disability Survey

MDSA: Model Disability Survey of Afghanistan

MoLSAMD: Ministry of Labour, Social Affairs, Martyrs and Disabled

NAC: Norwegian Afghanistan Committee

NGO: Non-governmental organisation

OCHA: UN Office for the Co-ordination of Humanitarian Affairs

OPDs: Organisations led by persons with disabilities

PTSD: Post-traumatic stress disorder

RWI: Raoul Wallenberg Institute

SDGs: UN Sustainable Development Goals

UNAMA: UN Assistance Mission in Afghanistan

UNCT: UN Country Team

USAID: United States Agency for International Development

WASH: Water, sanitation and hygiene

WHO: World Health Organization

EXECUTIVE SUMMARY

Introduction and Objectives

Guided principally by the Convention on the Rights of Persons with Disabilities (CRPD) and, on questions of unjust causation of impairment, by the International Covenant on Economic, Social and Cultural Rights (ICESCR), this study examines how the situation of persons with disabilities in Afghanistan has evolved since August 2021. Drawing on interviews conducted across all 34 provinces, it documents current living conditions and social inclusion, and asks a single overarching question: How has the situation for persons with disabilities evolved since the Taliban's return to power?

The study identifies the physical, social, educational and economic barriers that limit access to basic services and equal opportunities; documents the strategies persons with disabilities use to cope; and, guided by the ICESCR, examines how war, poverty and health-system failure can themselves cause or intensify impairment. It concludes with practical, evidence-based recommendations, developed with persons with disabilities, for policymakers, UN agencies, NGOs and service providers.

Methodology

The research followed a participatory, extended case method (Burawoy, 1998) rather than statistical sampling – a deliberate choice given the insecurity, surveillance and logistical constraints that make probability-based sampling both unsafe and impractical in current-day Afghanistan. The method prioritises analytical depth and structural insight over national representativeness; findings are therefore analytically grounded, rather than statistically representative.

- **Fieldwork** – September-November 2025; 99 interviews conducted face-to-face in Afghanistan (with online interviews for external stakeholders), reaching all 34 provinces, plus a supplementary art-therapy session with approximately 200 deaf children and youth at ANOD, Kabul.
- **Team** – four regionally based research Fellows, two organisations led by persons with disabilities (one DRG-trained), a central-highlands research assistant, and a co-ordinating team leader, all trained in research ethics, safeguarding and qualitative methods.
- **Sample composition** – 64 male and 35 female interviewees (99 total, including seven key-informant interviews); tools were developed in Dari/Pashto, translated to English for expert review, and back-translated, with at least one pilot interview per team.
- **Ethics** – consent grounded in CRPD Article 12 (with parental consent for minors); do-no-harm and risk-assessment protocols shaped recruitment, travel and data handling throughout.
- **Limitations** – insecurity, terrain, weak telecommunications and resource constraints limited reach into the most remote communities; the Taliban's restrictions on women required innovative, trust-based and online approaches to reach female respondents.

Key Findings by Section

Context and the Human Rights Framework

Afghanistan has ratified the CRPD (2012), ILO Convention 159 and the CRC, obligations that remain binding on the de facto authorities, regardless of political recognition. The report assesses disability as per the CRPD's human rights model – impairment interacting with attitudinal and environmental barriers – while applying Kimberlé Crenshaw's intersectionality to the compounded disadvantage facing women and girls with disabilities, and Beth Ribet's concept of "emergent disability" and "escalating disablement" (2011) to show how conflict, deprivation and poor healthcare themselves generate and intensify impairment.

Persons With Disabilities in Afghanistan

No recent national data exists; the 2019 MDSA remains the most substantial reference point, recording mild disability in 24.6% of adults, moderate in 40.4% and severe in 13.9%, with women somewhat over-represented in the severe category (14.9% versus 12.6% of men). Persons with disabilities in Afghanistan span physical/mobility, visual, hearing, communication, intellectual and/or developmental, psycho-social and multiple impairments – a highly diverse population that should not be treated as a uniform group.

Legal, Policy and Institutional Trajectory

- **Before 2021:** A relatively developed – if unevenly implemented – framework existed (2004 Constitution, 2010 Disability Rights Law, 3% employment quota, inclusive-education commitments), which was heavily dependent on NGOs and donor funding.
- **Since 2021:** The Afghan Independent Human Rights Commission has ceased functioning, employment quotas and rehabilitation strategies have stalled, and the former Ministry has split into two under-resourced bodies. Assistance is reported to be applied inconsistently and without transparent criteria; a December 2025 Taliban decree on disability affairs raises further concerns about politicised, rather than rights-based, distribution of support.

Understanding Disability in the Afghan Context

Afghan law and social attitudes remain predominantly impairment- and capacity-based (including percentage-based classification), in tension with the CRPD's human-rights model; the CRPD Committee has called for legislative harmonisation. Stigmatising terminology (such as *mayoub*, meaning faulty or defective) persists alongside disability-led advocacy for more affirming language (such as *malool*, meaning indisposed). Islamic jurisprudence, by contrast, grounds disability in human dignity and the removal of hardship (*raf' al-haraj*), offering a supportive frame that is under-used in practice.

Barriers to Services Before 2021

Even under the Republic, services were fragmented, urban-concentrated and NGO-dependent. Education access was severely limited by inaccessible schools and social attitudes; a modest disability allowance (~60,000 AFN/year) reached only some eligible people; healthcare and rehabilitation were concentrated in Kabul and a few provincial capitals; assistive devices depended almost entirely on the ICRC and a handful of NGOs; and psycho-social support was minimal and project-based. Cost, distance and availability were the dominant barriers throughout.

Barriers to Services Since 2021

Post-2021 testimony documents a sharp, multidimensional deterioration:

- Social stigma and exclusion: pervasive mockery, degrading language and loss of dignity, with direct psychological and even physical-health consequences.
- Gender-based barriers: women and girls with disabilities face compounded discrimination (mobility restrictions, guardian requirements, coerced marriage, abandonment), intensified by Taliban restrictions on women's public life.
- Healthcare access: geographical isolation, insecurity and poverty all delay or prevent treatment, transforming treatable injuries into permanent impairments.
- Education: near-total exclusion of girls with disabilities, low accessibility, and widespread poverty forcing children of persons with disabilities into labour instead of school.
- Economic marginalisation: collapse of livelihoods, inconsistent or discontinued disability allowances, and reports that assistance is increasingly allocated on political rather than needs-based grounds.
- Civic and political exclusion, exploitation and abuse: limited participation in decision-making, and heightened risk of neglect and exploitation, especially for children and persons with psycho-social and/or intellectual disabilities.
- Data invisibility, mobility, housing and accessibility: many persons with disabilities remain unregistered; transport, housing and public infrastructure remain largely inaccessible.

Overall, the shift since 2021 is characterised not merely as a decline in services but as a change from rights-based provision toward discretionary, selective and politicised assistance.

Injustice Causing Impairment

Applying the ICESCR alongside the CRPD, the report finds that impairment in Afghanistan is often produced or intensified by injustice itself: 61% of respondents attributed their impairment directly to the prolonged war (mines, gunfire, explosions), with additional pathways through interrupted vaccination (Afghanistan remains polio-endemic), untreated childhood illness, inadequate maternal and/or pre-natal care, and delayed or unaffordable emergency treatment. Testimonies repeatedly show treatable injuries becoming permanent impairments – including amputation – because of poverty, distance, insecurity or absent services.

Coping Strategies and Support Systems

In the near-total absence of state protection, persons with disabilities rely overwhelmingly on faith, family and informal community support, supplemented by unpredictable charitable giving (*zakat* and/or *sadaqa*, being obligatory or voluntary charitable acts, respectively). While these strategies demonstrate resilience, the report cautions against treating them as adequate substitutes for systemic protection: they shift responsibility from institutions onto individuals and families, normalising deprivation rather than resolving it.

Conclusion and Recommendations

Social stigma, gender inequality, economic marginalisation, service collapse and policy invisibility reinforce one another, disadvantaging women and girls and rural and/or conflict-affected populations most acutely. The de facto authorities retain full responsibility under Afghanistan's existing CRPD obligations, irrespective of political recognition. The report sets out an 18-point, phased action matrix (immediate 0-12 months; medium term 12-24 months; longer term 24-36 months) directed at de facto authorities, UN agencies, INGOs and/or NGOs, donors and communities, centred on:

- Institutional and humanitarian priorities: joint, disability-inclusive needs assessments; accessible humanitarian infrastructure; a phased disability data and mapping system; integration of rehabilitation and assistive technology into health services; expansion of Afghan Sign Language access; livelihood pathways; and community-based monitoring.
- Rights, social and community-level priorities: non-discriminatory, rights-based access to assistance; engagement of religious scholars and community leaders to reduce stigma; accessibility improvements in public spaces; strengthened family and/or community support; and greater participation of persons with disabilities in decision-making.
- Cross-cutting priorities: rights-based, non-stigmatising terminology; continuous feedback mechanisms; periodic intersectional research; and multi-actor delivery models that do not rely solely on a State authority lacking capacity or legitimacy.

The overarching call is to move from charity and episodic assistance towards rights-based inclusion, participation, accountability and agency, in other words – treating all persons with disabilities as rights-holders and agents of change, not only as beneficiaries.

1. Introduction

1.1. Objectives of the Study

Guided by CRPD as the leading international framework for disability rights, this study examines how the situation for persons with disabilities in Afghanistan has evolved since August 2021. In doing so, it aims to understand the lives and lived experiences, as well as the challenges and needs, of persons with disabilities across all 34 provinces, assessing their current living conditions and levels of social inclusion in diverse communities throughout the country. Guided by ICESCR, the report also addresses the injustices, such as war, poverty and lack of health, causing impairment in Afghanistan.

The study assesses the current living conditions and social inclusion of persons with disabilities across different provinces and communities in the country.

The overall question that this study is: *How has the situation for persons with disabilities evolved in Afghanistan since August 2021?*

The study intends to identify the key barriers – physical, social, educational and economic – that limit the access of persons with disabilities to basic services and equal opportunities, and the strategies that persons with disabilities adopt to overcome barriers. Consequently, the aim is to develop practical, evidence-based recommendations by persons with disabilities to guide policymakers, NGOs, and service providers in designing inclusive and effective disability support programmes.



2. Perspective of the Study

Understanding differently abled persons in Afghanistan from a human-rights perspective on impairment and disability requires attention both to lived realities and to the demands of human rights and justice.

2.1. Disability as a Question of Human Rights

The principal framework is the CRPD. It protects civil, political, economic, social and cultural rights across virtually all areas of life. These include accessibility, legal capacity, access to justice, protection from violence, independent living and inclusion in the community, education, health, rehabilitation, employment, an adequate standard of living, and participation in public and cultural life. This breadth matters because persons with disabilities have historically been approached mainly through healthcare and social protection. The CRPD, instead, affirms their right to the same range of experiences, relationships, opportunities and choices as everyone else.

The Convention is also explicit about implementation. Article 4 requires States to adopt legislative, administrative and other measures to realise Convention rights. Other provisions address accessibility, raising of awareness, support, data and participation. Persons with disabilities and their representative organisations must be closely consulted and actively involved in decisions concerning them. Some economic, social and cultural rights may be progressively realised, but obligations such as non-discrimination apply immediately.

Central to this framework is the CRPD's understanding of disability. The Convention distinguishes impairment from the disability that arises when impairment interacts with attitudinal and environmental barriers (CRPD, 2018). The focus is therefore on what happens when environments, institutions, attitudes and practices prevent persons with impairments from participating fully and equally in society.

This does not remove impairment, illness or healthcare from view. Impairment may be relevant to what a person requires in relation to healthcare, communication, accessibility or support – but it can never justify limiting a person's human rights. The CRPD asks what must change in society so that persons with disabilities can exercise their rights as they are.¹

2.2. Intersectionality and Women and Girls with Disabilities

A human rights perspective must also recognise diversity among persons with disabilities. Gender, age, ethnicity, poverty, geography and other circumstances may interact with disability and shape both exposure to harm and the barriers a person encounters.

The CRPD expressly addresses women and girls with disabilities. Article 6 recognises that they are subject to multiple forms of discrimination. The CRPD Committee has explained how disability and gender, together with other grounds for discrimination, can interact and produce distinct forms of disadvantage.

This reflects Crenshaw's concept of intersectionality. Crenshaw developed the concept to show how the combined effects of different forms of inequality can disappear from view when each is examined separately. This is particularly relevant in Afghanistan. Women and girls face extensive restrictions on education, employment, movement, healthcare and

¹ The account of the CRPD in this section is based on the work of Dr Anna Bruce in *Elgar Online Encyclopedia on Equality, Equity, Diversity and Non-Discrimination* (Edward Elgar, forthcoming 2027).

participation in public life. Disability, ethnicity, poverty and other circumstances may further shape how those restrictions affect them. Intersectionality helps explain why the experiences of women and girls with disabilities may differ from those of other women or other persons with disabilities.

This is also important in Afghanistan's predominantly humanitarian context. An intersectional approach draws attention to whether humanitarian needs assessments, data, services and monitoring include persons with disabilities in all their diversity and are accessible to them, rather than assuming uniform needs or vulnerability.

2.3. When Injustice Produces Impairment

Given the prevailing Afghan context, this report also considers a further human-rights issue, beyond that of the barriers for persons with disabilities; that is, the conditions in which impairments arise or become more pronounced.

The CRPD places its main focus on the rights, equality and inclusion of persons with disabilities rather than on preventing or correcting impairment. Alongside this framework, other parts of human-rights law help us examine how injury, illness, trauma and impairment may themselves be shaped by injustice. Article 12 of the ICESCR protects the right to the highest attainable standard of physical and mental health. The Committee on ESCR has explained that this includes not only healthcare but also underlying conditions such as food, housing, safe water and sanitation, and healthy working and environmental conditions. Conflict, violence, deprivation, poverty and lack of access to healthcare can thus contribute to injury, illness and psychological harm, or make existing conditions more pronounced.

Ribet's work on "emergent disability" helps explain this connection. Ribet draws attention to physical, cognitive and psychological conditions that are produced wholly or partly through social inequality or State violence. Examples include mass violence; deprivation of healthcare, nutrition or housing; labour exploitation; environmental hazards; and inter-personal violence. Her concern is with understanding how power and social conditions can cause injury and illness.

Ribet also describes a process of "escalating disablement". Injury, trauma or illness may first arise in violent or deprived conditions. Social and economic disruption and inadequate healthcare may then make the harm more pronounced or lasting. The resulting impairment, when overlaid with poverty, stigma or other disadvantage, may in turn increase exposure to further harm. When this happens on a large scale, communities may also become less able to respond adequately to the needs that result. This is useful for understanding how different forms of injustice can reinforce one another over time.

3. Methodology

In this study, our approach was unique in many aspects. We did not consider this study as a one-way extractive research in which data is collected then a report is produced. Throughout this process, over a period of six months, the participants – whether the Fellows, research assistants from organisations for persons with disabilities or key informants – all took part in a participatory way in which where their views, perspectives and suggestions shaped the design, analysis and outcome of this study. We followed the extended case method, which allows researchers to observe and record their reflections, and combine them with those of their informants during the interview process.

The extended case method was well-suited for this study because it emphasises theoretical elaboration of CRPD through strategically selected cases rather than statistical representativeness. As Burawoy (1998) argues, the strength of the approach lies in its capacity to situate micro-level experiences within broader social, political and historical structures, allowing researchers to treat contextual diversity not as noise but as a source of analytical insight. This is essential in Afghanistan, where the experiences of persons with disabilities vary widely across the country's 34 provinces due to differences in conflict exposure, gender norms, local governance dynamics, cultural practices and access to services. Given the logistical and ethical constraints of conducting representative sampling in the current Afghan context, where the Taliban's restrictive policies and surveillance environment make conventional probability-based sampling both difficult and potentially unsafe, the extended case method provided a suitable methodological approach. Rather than seeking statistical representativeness, the method enabled the study to purposively select cases across diverse geographical and institutional settings and use them to trace how broader structural forces – including restrictive policies, institutional capacity, access to resources, social norms and patterns of exclusion – shape the availability, accessibility and delivery of disability-related services. This allowed the study to move beyond individual experiences to identify common mechanisms, patterns and structural relationships operating across different contexts while remaining sensitive to the ethical and practical constraints of research in Afghanistan.

The data collection period was from September to November 2025. All interviews were conducted inside Afghanistan or online with relevant stakeholders out of the country.

3.1. Criteria for Selection of Interviewees

The interviews took place, in most cases, face-to-face, at the place of choice of the persons with disabilities, where they feel comfortable. The research team set criteria for the selection of interviewees to be more diverse geographically, in terms of gender, age, ethnicity and types of disabilities. As Tom Shakespeare (2006) warns, claims of broad representation in disability and impairment research are problematic because persons with disabilities do not form a uniform group. They hold multiple and intersecting identities – such as gender, ethnicity, class, socio-economic position and psycho-social experiences – that are as varied as those found in the wider population.

As disability is only one dimension of who they are, it is essential to attend to the diversity and specificity of their voices rather than striving for an impossible full representation. The four research Fellows used their own trusted networks to reach out to persons with disabilities in the provinces surrounding their regions, while the organisations of persons with disabilities involved in the study were instructed to cover the six remaining provinces, where one to three interviews were conducted with persons with disabilities in person. Each interview included a section for the researchers to note their own observations about the

conditions and surroundings of the place and time where the interview was conducted. All

	Research Team	Regions Covered	Male	Female	Total Number of Interviews
1	Research Fellow Northern and SE & Southern Regions	Northern South Eastern & Southern	16	6	22
2	Research Fellow Central Region	Central Region including Kabul	11	9	20
3	Research Fellow Western Region	Western Region	14	7	21
4	Research Fellow Eastern Region	Eastern Region	7	5	12
5	Research Partner and Persons with Disabilities-led Organisation	Remaining Provinces	10	4	14
6	Local Research Assistant	Central Highland	2	1	3
7	Team Lead	Key Informant Interviews (KII)	4	3	7
	Total		64	35	99

data-collecting teams received a series of research training on the development and design of the data-collection tools and their testing. Furthermore, the ethics and humanitarian principles of impartiality, neutrality and “do no harm” were well explained to ensure the study is up to global standard. The study team remained committed to being as inclusive as possible in the full coverage of the 34 provinces within the prevailing context.

3.2. Research Team Composition

The team composition included four research Fellows who are stationed in different regions of Afghanistan; two well-respected organisations led by personas with disabilities in Afghanistan, one of which had a team trained by DRG and helped with data collection, the other provided space for gathering reflections from children with disabilities through art therapy sessions; one research assistant in the central highlands; and a team leader and assistant who co-ordinated the study virtually. Each team member had a critical role in the tool design and development; they were all trained in research ethics and in conducting qualitative data collection, and were trained and mentored in each phase of the study, including the literature review and the data-collection process. The tools were developed originally in local languages, translated into English, reviewed by DRG and RWI experts, then back-translated to Dari and Pashto. Each Fellow and partner organisation tested the tool with at least one interview conducted and fully transcribed. This was all necessary for quality assurance as well as for training purposes. The table below presents the data-collection process.

In each province, at least two persons with disabilities were interviewed. There are only exceptional contexts in which female interviewees were not accessible; otherwise, there is relatively good representation within the context of female interviewees. The KII were not all persons with disabilities and included members of various organisations and INGOs working on disability issues in Afghanistan.

3.3. Reflections from the Children with Disabilities Through Art Therapy

In addition to the interviews noted in the table, the research team made use of ArtLords, which is an “artist collective” comprising professional artists who provide art therapy sessions for different communities in Kabul. Three artists, including one female artist, attended a session with about 200 students from ANOD in Kabul, where girls and boys with hearing disabilities attend schools. The ArtLords team followed the ethical procedure of obtaining all necessary permissions before their activities. The students took part in a four-hour activity in which they received painting materials to express themselves and envision their future. Some of these paintings, as well as reflections from these students, are included in the analysis of this report following consent from the organisation. Parental permission for the children with disabilities to attend this therapy session, was sought through ANOD.

It has to be noted that the comprehensive restrictions on women were a critical barrier that was overcome by the team through innovative ways of conducting interviews, facilitated by trusted network and contacts in each locality. An online option was used if a disabled interviewee felt more comfortable with that method. Furthermore, the professional background of Fellows being involved in humanitarian aid or communications helped them build trust between the interviewee and researchers.

3.4. Interview Consent

The research team was guided by Article 12 of the CRPD that indicates an adult person with disability holds rights to consent (or not) by themselves. For interviews with minors, consent was sought from the parents, who were present during the interview. In the case of ANOD, given that it was a collective activity with the students of their centre, consent was obtained from ANOD management who agreed with the art activities. Interview consent was recorded for all interviews after the researcher explained the study process and expected outcomes.

3.5. Research Ethics and Limitations

Conducting rigorous research in Afghanistan under the Taliban’s restrictive governance required balancing robust evidence with the safety, dignity, privacy and autonomy of participants and researchers. The team received training in research ethics, safeguarding, informed consent, confidentiality, and risk management, with systematic risk assessment guiding recruitment, data collection, travel, communication and data protection. The principle of “do no harm” shaped methodological choices if participation or disclosure could expose individuals to risk.

The study, nevertheless, faced significant access and coverage constraints, including insecurity, difficult terrain, limited transport, weak telecommunications and resource limitations. These barriers particularly affected access to persons with disabilities in remote and isolated communities, limiting representativeness and national generalisability. The findings should, therefore, be understood as analytically grounded rather than statistically

representative. These limitations reflect both practical constraints and deliberate, ethical choices to prioritise participant safety while maximising the diversity, depth and analytical value of evidence that could be responsibly collected.

4. An Overview of the Context

In Afghanistan, the situation for persons with disabilities has never been good; however, it has deteriorated catastrophically in recent years, a direct consequence of more than four decades of war, severe droughts and natural disasters, such as the string of major earthquakes between 2022 and 2025. Beyond the armed conflict and natural disasters, the situation of persons with disabilities in Afghanistan is increasingly shaped by political exclusion, drastic aid conditionality and economic collapse. The country's long-standing, massive dependency on international aid created a fragile support system, which has now been shattered by drastic aid cuts since 2022. This has led to the collapse of essential services, including rehabilitation programmes, assistive device provision and inclusive education initiatives funded by external donors. Decisions related to aid suspension, service centralisation and regulatory restrictions disproportionately affect persons with disabilities, whose survival depends on proximity to services, social protection and community acceptance.² And, as one researcher noted, even in some provincial capitals, the only clinic that exists is able to treat patients with simple painkillers, such as paracetamol and nothing more.³ Even so, sadly, the recent border closure with Pakistan has made it nearly impossible to access many basic services.

A 2024 report by HRW details how the Taliban's regressive policies and the economic crisis have disproportionately impacted persons with disabilities, with many being unable to access humanitarian aid due to mobility barriers and discrimination. Faced with this compounded shock, coping mechanisms are often measures of last resort. Many rely solely on strained familial support, while others are forced into begging – a practice that has visibly increased in urban centres and where Taliban members try to pull them off the streets.⁴

Community-based, informal support networks have become a lifeline and some resilient individuals engage in home-based micro-enterprises where possible. However, the systemic absence of a social protection framework and the targeted exclusion of women and girls – including those with disabilities – from public life and assistance programmes under Taliban rule, have pushed persons with disabilities to the brink, exemplifying a severe human rights and humanitarian crisis.

4.1. Persons With Disability in Afghanistan

Persons with disabilities constitute a large and diverse part of the Afghan population. They include women and men, girls and boys, younger and older persons, and people living in rural and urban areas across the country. They also belong to Afghanistan's different ethnic, linguistic and social groups. Persons with disabilities are thus not a single or uniform group, and their lives, identities and circumstances vary considerably.

There is no recent comprehensive national data on the number of persons with disabilities in Afghanistan. The most substantial available national study is the MDSA, conducted in 2019. The survey found that 24.6% of adults experienced mild disability, 40.4% moderate

² KII-M-INGO-02092025

³ Observation notes from southern and eastern region.

⁴ "The Taliban have systematically rounded up and removed beggars from the streets, with more than 29,000 people reportedly collected in Kabul by March 2023, including many women and children. The policy has disproportionately affected women, many of whom were pushed into begging by restrictions on employment and livelihoods. Pajhwok Afghan News: *29,403 beggars rounded up in Kabul*. 14 March 2023. <https://pajhwok.com/2023/03/14/over-29000-beggars-rounded-up-in-kabul/>; Amu TV: *Taliban claim to have rounded up 62,000 beggars in past year*. 20 October 2024. (Accessed on 12 April 2026). <https://amu.tv/131699/>

disability and 13.9% severe disability. Women were somewhat more represented in the moderate and severe categories: 14.9% of women were classified as experiencing severe disability, compared with 12.6% of men (Shinwari, et al., 2020). These figures should be used with some caution; the survey is now several years old and was conducted under difficult security conditions.⁵

The MDSA does not define disability simply through particular diagnoses or impairments; it measures disability across a continuum of functioning, in line with the WHO Model Disability Survey approach.⁶ Within the Afghan population, persons with disabilities include those with physical or mobility impairments; blind and partially sighted; deaf and hard-of-hearing; those with communication disabilities; those with intellectual or developmental disabilities; those with psycho-social disabilities; and persons with multiple impairments. These categories can be useful for describing the diversity represented in the population, but they do not define the individuals concerned or capture the full diversity of their identities, circumstances and experiences.

Physical and mobility impairments encompass a wide range of bodily and mobility-related impairments, including limb differences or loss, paralysis, reduced mobility, and impairments affecting movement, strength or co-ordination. People within this broad category may use wheelchairs, crutches, prostheses or other mobility devices, while others do not use any assistive devices.

Visual impairments include blindness and different degrees of partial sight or low vision. Blind and partially sighted people are themselves diverse, including people who have been blind from birth or childhood and people who acquire visual impairments later in life.

Deafness and hearing impairments include deaf people and people who are hard of hearing. These terms are not interchangeable. For some deaf people, deaf identity is also linguistic and cultural and is connected to the use of sign language.

Communication impairments should likewise be distinguished from deafness and hearing impairment and can include impairments relating to speech, language or other forms of communication.

Intellectual and developmental impairments encompass a broad range of intellectual and developmental differences. People within these categories have diverse abilities, ways of communicating and ways of experiencing and engaging with the world, and should not be treated as a single homogeneous group.

Psycho-social impairments encompass a wide range of experiences associated with long-term or recurrent psychological distress or mental health conditions. The term does not describe a single condition or experience, and persons with psycho-social impairments are themselves highly diverse.

Some people have **multiple impairments**, for example, combinations of physical, sensory, intellectual, developmental or psycho-social impairments. The presence of more than one impairment does not itself define a person's identity or circumstances, and the combinations involved can vary considerably.

These categories are neither exhaustive nor mutually exclusive. A person may identify with more than one of them, and terminology may also vary according to individual preference,

⁵ Akseer Shinwari, Tabasum Akseer and Mahdis Kamali (n. 1), Appendix 5.7. *Incidents during Field Work*. 183–191. The appendix documents security incidents occurring during the period of data collection.

⁶ The MDS is based on the ICF and approaches disability as a continuum, taking account of the interaction between the person and the environment.

language and community. Their purpose here is thus not to classify persons with disabilities into fixed groups, but to make visible some of the diversity of impairment represented within Afghanistan’s population.

4.2. Reports and Studies on Disabilities in Afghanistan since 2021

The table below presents key reports and publications issued since 2021 that document the evolving situation for persons with disabilities in Afghanistan following the return of the Taliban to power. Before 2021, despite significant implementation gaps, Afghanistan had developed a relatively broader legal and policy framework on disability rights, including constitutional protections, rehabilitation programmes, inclusive education commitments and engagement with the CRPD. However, post-2021 reports consistently indicate a deterioration in the conditions for persons with disabilities due to institutional collapse, restrictions on women’s participation in public life, reduced humanitarian access, shrinking rehabilitation and healthcare services, and the weakening of State protection mechanisms.

The publications highlighted below collectively document the intersection of disability, gender, poverty, conflict and exclusion, while also illustrating how Taliban policies and broader humanitarian crises have intensified barriers to healthcare, mobility, education, employment and civic participation for persons with disabilities across the country.

Title / Publication	Primary Focus	Link
Human Rights Situation of Persons with Disabilities in Afghanistan (2021-2025)	The Rahyab Initiative: Comprehensive assessment of rights violations, specifically focusing on access to justice, health, and the exclusion of the blind community.	View Report
Persons with Disabilities Under the Taliban Regime (2021-2024)	Legal and academic inquiry into the dismantling of support structures and international obligations (CRPD).	View Report
UNAMA Human Rights Situation in Afghanistan (March 2026)	Monitoring of human rights, including the impact of the Propagation of Virtue and the Prevention of Vice Laws on the mobility of persons with disabilities.	View Report
HRW World Report 2025: Afghanistan	Analysis of the healthcare collapse and the disappearance of specialised rehabilitation services.	View Report
HI Annual Report 2024	Field data on explosive remnant casualties and the status of physical rehabilitation centres.	View Report

Title / Publication	Primary Focus	Link
World Bank Afghanistan Development Update (November 2025)	Economic data on household vulnerability and food insecurity in families with disabled members.	View Report
Special Rapporteur Report (A/HRC/58/80)	UN assessment of the systematic exclusion of women with disabilities from health and civic life.	View Report
CRPD/C/AFG/Q/1 (July 2022)	List of issues in relation to the initial report of Afghanistan submitted in 2020	View Report
World Policy Analysis Centre 15th Pre-Session Working Group March 2022	Afghanistan: Brief on the Implementation of CRPD Commitments for Articles 3, 5, 27 and General Comment No. 6	View Report

4.3. Legal, Policy and Institutional Framework Trajectory

International Commitments

Afghanistan has ratified all three major international instruments protecting the rights of persons with disabilities and children – CRPD (ratified on 18 September 2012); ILO Convention No. 159 on Vocational Rehabilitation and Employment (Disabled Persons) (ratified on 7 April 2010); and CRC (ratified in 1994). These ratifications remain legally binding on the Afghan State under international law, even as domestic enforcement mechanisms have weakened or nearly collapsed since 2021.

The most significant is the CRPD, which obliges the State to ensure equality, non-discrimination, accessibility, inclusive education, employment and participation for persons with disabilities (CRPD, 2006). ILO Convention No. 159 (1983), reinforces obligations to support equal labour market access for persons with disabilities. CRC further commits Afghanistan to protect the rights of children with disabilities, including access to health, development and inclusive education (CRC, 1989). The SDGs and the “leave no one behind” (LNOB) principle provide an additional global framework encouraging systematic disability inclusion across education, employment, social protection and data systems (UN, 2030 Agenda for Sustainable Development, 2015).

National Legal and Policy Situation Before 2021

Between 2004 and 2021, Afghanistan developed a relatively comprehensive – though unevenly implemented – disability policy architecture. The 2004 Constitution prohibited discrimination (Art. 22) and mandated state support to persons with disabilities (Art. 53). The Law on the Rights and Benefits of Disabled Persons (2010) established social support, rehabilitation rights, and a 3% employment quota in public and private sectors (MoLSAMD, 2010). The Education Law (2008) required the provision of education for children and adults with disabilities. This framework was further reinforced by the 2010 Kabul Declaration on Inclusive and Child-Friendly Education, which committed the government and partners to

advancing inclusive, child-friendly education systems, including improved access and participation for children with disabilities. Before 2021, Afghanistan had a substantial national framework for disability rights, centred on the 2009 Law on the Rights and Privileges of Persons with Disabilities, the Afghanistan National Disability Action Plan (2008-2011, later extended), and successive health-sector rehabilitation strategies. These frameworks envisaged social protection, rehabilitation, education, employment, accessibility and participation, including a 3% employment quota. However, implementation remained uneven: services were heavily NGO-dependent, geographically concentrated, and limited by weak institutional capacity, inadequate data and poor co-ordination.⁷

National Legal and Policy Situation Since 2021

Following the Taliban's takeover in August 2021, disability-rights protections deteriorated sharply. Institutions responsible for monitoring rights, such as the Afghan Independent Human Rights Commission, ceased functioning. Government-led inclusive education programmes, employment quotas and rehabilitation strategies have largely stalled due to aid cuts as well as the Taliban's restrictions on girls' education and women's work. The humanitarian and economic crisis has disproportionately affected persons with disabilities, who face reduced access to health services, assistive devices, psycho-social support and accessible public infrastructure (HRW, 2022).

As one international aid worker based in Kabul⁸ said:

"We used to have a national disability strategy as well, but its implementation is really weak, especially under the current political circumstances ... And then, of course, as we all know, there's a shrinking civic space for organisations led by persons with disabilities [OPDs] and civil society. So we are all very much aware of this situation."

Another OPD director added that, in the current context, almost none of the former Republic policies are effective. More precisely, the Ministry of Public Health has almost no policy or obligation for persons with disabilities. MoLSAMD, which was relatively active in the past and which is currently split into two separate ministries, the Ministry of Labour and Social Affairs and the Ministry of Martyrs and Disabled Affairs, both continue to have very limited technical capacity and deal with a far too limited budget, and apply the same restrictive policies as other ministries with no exceptions.

For the Taliban authorities, in relation to persons with disabilities, there is no written policy to be considered; however, there are several examples of unwritten policies that they implement without a formal reference to any law or regulation. One key informant interviewee shared the following with us about such policies:

*"If a person with disabilities has a condition, like losing one leg or one eye or has a hearing disability, they are not considered a person with disabilities for the payment entitlement. A person with mental health issues is also not considered a person with a disability and so does not receive the monthly allowance. It is not clear how they decide that."*⁹

⁷ Government of Afghanistan (2021). *Initial report submitted by Afghanistan under Article 35 of the Convention, due in 2014*. UN CRPD/C/AFG/1. [Report source](#) (Accessed on 13 August 2026).

⁸ KII-M-INGO-02092025

⁹ KII-M-Persons with Disabilities-led NGO-KBL-08122025

As this report was being first drafted, on 16 December 2025 national media reported that Hibatullah Akhundzada had issued a decree instructing the Ministry of Labour and Social Affairs to take measures concerning persons with disabilities, though the scope, implementation mechanisms and alignment with international standards remain unclear.¹⁰ In the absence of transparent criteria and oversight, there is a risk that such a policy could reinforce existing patterns of unequal assistance, enabling Taliban authorities to prioritise support for affiliated or former members over ordinary persons with disabilities. This raises concerns that aid and social protection services may be distributed based on political affiliation rather than need, potentially entrenching discrimination and undermining principles of equality and non-discrimination.

Children with disabilities are particularly affected by school closures, restricted access to education – especially for girls – and the absence of organised support services. Civil society organisations and disability-focused NGOs report reduced operational capacity due to funding cuts and restrictions on movement.¹¹

The SDGs and the LNOB agenda have also been severely affected since August 2021 due to aid cuts and various restrictions. Delivering humanitarian aid is a priority, but SDG benchmarks have fallen off the donors', implementors' and the State's agenda. INGOs and some national NGOs, are increasingly responsible for providing disability-inclusive services – such as accessible aid distribution, disability-sensitive disaster response and data collection.¹² However, speaking to the majority of persons with disabilities and observing the humanitarian services for the last four years, it is evident that meaningful, disability-inclusive humanitarian aid or development aid is neither anyone's priority, nor has survived the brutal aid cuts led by USAID and followed by other international aid donors.¹³ The most critical point is that a rights-based approach to disability has been severely weakened or almost dismantled.

UN agencies have repeatedly stressed the need to prioritise persons with disabilities in humanitarian operations and to support their participation in decision-making (UNCT Afghanistan, 2025).¹⁴ However, progress remains highly dependent on donor commitment, security conditions, and the operational space available to all stakeholders to respond to the needs of persons with disabilities in a sustainable and meaningful way.

In sum, before 2021 Afghanistan had developed a legal and policy framework broadly aligned with international standards but weakly implemented. After 2021 and the new, restrictive regime, as discussed earlier, institutional protections collapsed and disability inclusion became reliant on humanitarian actors, which have already been severely hit by aid cuts. International frameworks' essential reference points for any long-term progress remain contingent on restoring functional national systems, inclusive education, rehabilitation services and employment pathways.

¹⁰ Habib Mohammadi (16 December 2025). Amu TV: *Taliban leader claims his decrees guide people toward Islam*. <https://amu.tv/216263/>. (Accessed on 18 December 2025)

¹¹ KII-M-INGOH102092025.docx

¹² KII-M-INGONAC02092025.docx

¹³ HRW (2025). *World Report 2025: Afghanistan*. [Human Rights Watch – World Report 2025: Afghanistan](#); European Union Agency for Asylum (2026). *Afghanistan: Country Focus – Humanitarian situation*. [EUAA – Afghanistan Country Focus](#)

¹⁴ UNCT Afghanistan. *Statement on the International Day of Persons with Disabilities* (2025). <https://afghanistan.un.org/en/306392-un-afghanistan-statement-occasion-international-day-persons-disabilities>

4.4. Understanding of Disability in the Afghan Context

Legal Understanding of Disability

In line with the CRPD, this study approaches disability as the result of the interaction between impairments and societal or environmental barriers that hinder full and equal participation in society.

Afghanistan's legal definition of disability shares the CRPD's objective of participation and inclusion of persons with disabilities in society and in communities. However, the Afghan legal framework remains predominantly impairment- and capacity-based, including a percentage-based classification of disability, whereas the CRPD adopts a human-rights model in which disability results from the interaction between impairments and environmental and attitudinal barriers. The CRPD Committee has consequently called on Afghanistan to harmonise its legislation with the Convention and move away from the medical model of disability.¹⁵

Social Understanding of Disability

The social understanding of disability in Afghanistan is still shaped by a focus on impairment as a medical problem and a personal deficit. The CRPD focus on the barriers that interact with impairment and hinder full and equal participation in society (disability) is still largely missing from both social policy, and community and individual attitudes.

This is visible from earlier reports and discussions including the CRPD Committee in 2022 and the report prepared by The Rahyab Initiative in 2025. These sources confirm that social stigma around disability is even entwined in the local languages, where *mayoub* is used for a person with disabilities. The choice between *mayoub*, *malool*, and other Dari or Pashto terms should not rest on etymology alone. Terminology carries different religious, social, administrative, regional and conflict-related meanings and may be experienced as stigmatising or affirming in different contexts. In Afghanistan, *malool* is widely used by OPDs, particularly in relation to war-acquired disabilities; while *mayoub*, derived from Arabic, more directly conveys the notion of a “defect” or deficiency. Such deficit-oriented terminology can reinforce perceptions that disability defines a person's limitations, overlooking their abilities, agency and contribution.

Terminology also has practical implications for self-identification, social acceptance, and access to assistance and services. Accordingly, OPDs have advocated for *malool* as a more appropriate term. This is an example of how the participation of persons with disabilities themselves drive the battle against social stigma and discrimination. The CRPD Committee, in its list of issues addressing the former Republic government's submission in 2020, emphasises the question of terminology and calls for its revised legislation, policies and measures.¹⁶ This preference should, nevertheless, be validated through OPD consultations

¹⁵ UN CRPD Committee, List of Issues in relation to the Initial Report of Afghanistan, CRPD/C/AFG/Q/1, 21 July 2022, para. 1(a) https://tbinternet.ohchr.org/_layouts/15/treatybodyexternal/SessionDetails1.aspx?SessionID=2540&Lang=en; UN CRPD Committee, Initial report submitted by Afghanistan under Article 35 of the Convention (CRPD/C/AFG/1, 2020), paras. 36–37. [UN CRPD Afghanistan Report \(2020\)](#); Model Disability Survey of Afghanistan, 2019:52. See References.

¹⁶ UN CRPD Committee. List of Issues in Relation to the Initial Report of Afghanistan, para 1 a). CRPD/C/AFG/Q/1. Geneva: UN, July 21, 2022. [UN Digital Library](#)

and focus groups across linguistic, regional, gender and disability groups to ensure that the terminology adopted reflects how persons with disabilities understand and wish to describe themselves.

Disability in Islamic Practices

Islamic jurisprudence (*fiqh*) approaches disability through the overarching ethical objectives of the Shari'ah (*maqāṣid al-shari'ah*), which means goals and purposes of Shari'ah, particularly the preservation of human dignity (*hifz al-karāmah*), life, intellect and welfare (Kamali, 2008). Disability is not viewed as a moral deficiency or divine punishment, but as part of human diversity and a test of social responsibility. The Qur'ān affirms the inherent dignity of all human beings (Qur'ān 17:70) and explicitly removes blame and hardship from persons with disabilities (Qur'ān 24:61; 48:17). Mohammad Hashim Kamali emphasises that justice and compassion are central legal values in Islam, requiring the removal of hardship (*raf' al-haraj*) and the facilitation of ease (*taysir*) for vulnerable groups (Kamali, 2003). In his work on Islamic law and human rights, Kamali argues that legal rulings must respond to context to ensure inclusion, equity, and social participation for persons with disabilities (Kamali, 2002).

Additional scholarly support is found in the work of Abdulaziz Sachedina, who grounds disability ethics in the Qur'ānic principle of moral equality and communal care, emphasising rights rather than charity (Sachedina, 2009). Mohammad Fadel (2007) likewise highlights that Islamic legal theory prioritises substantive justice and social welfare, obligating Muslim societies to remove structural barriers that marginalise persons with disabilities. The Prophetic practice – appointing individuals with disabilities to public roles and affirming their full moral agency – establishes a lasting jurisprudential model of respect, inclusion, and empowerment (al-Qaradawi, 1995). A great example of this is the appointment of Abdullah ibn Umm Maktum as governor of Madina by the Prophet based on his exceptional abilities and integrity, demonstrating that merit – not physical ability, as he had been blind from birth – was the basis for leadership.

5. Persons with Disabilities Accesses to Services Before 2021

Before 2021, access to services for persons with disabilities in Afghanistan existed within a fragmented and uneven system shaped by decades of conflict, poverty, weak State capacity and heavy reliance on international humanitarian actors. While the former Republic formally recognised disability as a social and humanitarian issue and introduced limited support mechanisms, actual service delivery remained highly limited, under-resourced, and inaccessible for large segments of the population with disabilities, particularly those living in remote provinces. Access was largely determined by geography, economic status, gender norms and institutional capacity rather than legal entitlement. As a result, although some progress was made in urban areas, most persons with disabilities continued to face systemic exclusion from healthcare, education, livelihoods and social protection (UNCT, 2025).

5.1. Educational and Vocational Training

Before 2021, some efforts had been made to include persons with disabilities in education and vocational training systems, but access remained severely limited and unequal. Despite those efforts, in urban areas a small number of persons with disabilities, primarily men, were able to attend schools, universities or vocational training programmes. In contrast, mostly in remote and rural areas, access to education for persons with disabilities has been extremely limited due to war, poor road access and limited capacities and resources.¹⁷

Physical barriers played a major role. Most schools lacked ramps, accessible classrooms, adapted toilets or transportation facilities. Educational materials were not adapted for students with visual or hearing impairments, and specialised programmes, such as Braille education or sign language training, were scarce. A 44-year-old woman from Herat said:

“When I was young, there was no school to teach sign language to get education.”¹⁸

A 24-year-old woman shared a similar story:

“I studied until 8th grade. My brother took me to school by wheelbarrow. When we moved to another area, the school was on a hill, so it was difficult for him to take me to school in a wheelbarrow uphill. Then the Taliban came, and now I can’t go to school at all.”¹⁹

Social attitudes also constituted a significant barrier. Negative perceptions of disability among teachers, school administrators and fellow students discouraged enrolment and staying in educational centres. Many persons with disabilities reported being discouraged from attending school, facing discrimination and financial barriers. A mother whose daughter has mobility-based disability said:

“Because my daughter was very young, she could not tolerate some of the words and comments she heard outside the home. As a result, she became very withdrawn and socially isolated, as other children called her lame and because of this my daughter returned home crying. No matter how much I tried to encourage her to go to school and continue her education, she refused to do so.”²⁰

¹⁷ Collective observation from researchers during this study.

¹⁸ HRT-D9-F2-Naf-F-05092025

¹⁹ KDR-DND-F3-KCH-F-17092025

²⁰ FAR-D1-F2-Ng-F-1892025

Women and girls with disabilities faced compounded exclusion. Cultural norms, security concerns and lack of family support severely limited their educational opportunities, particularly in rural areas. While some women with disabilities in cities managed to access education, the majority remained excluded (HRC, 2020).

Vocational training programmes existed but were limited in number and scope. Many were short-term, donor-funded projects without long-term employment pathways. As a result, even those who completed training often struggled to find sustainable livelihoods (UN Women, 2024).

5.2. Economic and Social Assistance

Economic and social assistance before 2021 primarily took the form of a disability allowance administered by the Ministry of Martyrs and Disabled Affairs, along with humanitarian aid distributed by NGOs. Registered persons with disabilities were entitled to an annual allowance of approximately 60,000 AFN, which was generally distributed on a regular schedule. A 52-year-old man talked about his financial situation, saying:

“When I became disabled during the time of the Republic, I registered myself with the department of persons with disabilities of Takhar province. I was getting 60000 AFN annually.”²¹

Although modest, this allowance provided a crucial source of income for many households and helped cover basic needs, such as food, healthcare or transportation. However, access to the allowance was uneven. Many eligible individuals, especially in remote districts, were excluded due to lack of information, or bureaucratic barriers such as the absence of civil documentation. A 55-year-old man shared his experience:

“I was referred to many organisations, but I didn’t receive any assistance and I was asked me to come [again] ‘today or tomorrow’. You couldn’t get any kind of assistance without personal connection. I sold my cow to cover the cost of my surgery and got a loan for the rest of my treatment.”²²

Gender norms further restricted access. In some families, women with disabilities were not allowed to register or receive disability cards, effectively denying them financial support.²³ Additionally, the allowance alone was insufficient to meet the needs of households facing high costs.²⁴

NGOs and international agencies provided additional support through food aid, cash assistance and livelihood projects, often prioritising persons with disabilities. Ultimately, the lack of sustainable employment opportunities meant that many individuals remained dependent on assistance rather than achieving economic independence.

²¹ TKR-CTL-F1-AH-M-06092025

²² LOG-PA-GA-AH-M-03112025

²³ KII-F-Persons with disabilities-ledNGO05062025

²⁴ KII-M-Persons with Disabilities-ledNGO-KBL-08122025

5.3. Healthcare and Rehabilitation

Healthcare and rehabilitation services for persons with disabilities were formally available through governmental hospitals, public clinics, and international humanitarian organisations such as the Red Cross, Red Crescent, and the Swedish Committee for Afghanistan. In principle, persons with disabilities were entitled to free or subsidised treatment.²⁵ In practice, however, access to quality healthcare was highly unequal and geographically concentrated in Kabul and a limited number of major provincial capitals. A 32-year-old male respondent noted:

*“I was living in the remote district of Badghis, so I couldn’t get immediate treatment. After some time I did get treatment.”*²⁶

Another respondent, a 20-year-old woman, said that poverty hindered her from accessing the treatment she needed:

*“Since I got this disease, I have been completely paralysed. My father was poor and couldn’t afford my treatment. He was illiterate. Once I went to Kabul, to Maiwand Hospital, but there was no treatment there either. We faced lots of problems. We didn’t have the money to go to Pakistan for treatment.”*²⁷

Specialised services, such as physical rehabilitation, orthopaedic care and post-injury treatment, were largely absent at district and rural levels. Many provinces lacked specialist doctors, rehabilitation therapists and adequate medical equipment. District clinics were often limited to basic care and referrals, which meant that persons with disabilities were required to travel long distances to reach provincial or national hospitals (HRW, 2020).

For individuals with mobility impairments, visual impairments or chronic pain, this travel requirement posed a significant physical and financial burden.

A 43-year-old man, who has had multiple disabilities since childhood, shared his story:

*“It was during the war; this area was under the control of the Islamic Party [Hezb-e-Islami]. No one was able to go to the city or come from the city here. My mother was illiterate and didn’t know how to take me to a doctor. Later, my brother took me to Pakistan for treatment, but it was useless as lots of time had passed, or maybe we did not have enough money for my treatment.”*²⁸

The lack of timely and continuous treatment had serious consequences. Delays in emergency care, interruptions in medication, and absence of follow-up rehabilitation frequently resulted in preventable complications, deterioration of health conditions and impairment. Poverty played a decisive role: many families were unable to afford transportation costs or accommodation in urban centres, leading to delayed care or complete abandonment of treatment.

Healthcare access was therefore a structural issue in which health and impairment outcomes were directly shaped by poverty, location, and the absence of decentralised health infrastructure.

²⁵ KII-M-INGOH102092025.docx

²⁶ BDS-D4-F2-AbKh-M-2092025

²⁷ SMN-RDB-F1-ML-F-12092025

²⁸ KBL-QLQ-F3-HBN-M-26082025

5.4. Assistive Devices

Access to assistive devices was extremely limited and their availability was heavily dependent on a small number of international organisations. Artificial limbs, crutches, wheelchairs, prosthetics, orthotic devices and other mobility aids were primarily provided by the ICRC, the NAC, and a few specialised NGOs.²⁹ These organisations were widely respected for the quality of their services and respondents in the study generally expressed satisfaction with the technical standards of the devices they received. The 34-year-old male respondent mentioned his experience with the Red Cross:

*“I am registered with the Red Cross. My prosthetic hand was given to me by the Red Cross. Whenever I need an examination or if I have any problems with my hand, I go, and they adjust it and test it for me for free.”*³⁰

However, coverage was far from sufficient. As the number of service centres was very limited, most were located in major cities. In many cases, a single centre served multiple provinces, resulting in overcrowding, long waiting periods, and repeated travel requirements for fittings, repairs and follow-up care. For people living in remote districts, accessing these services could take months or even years.³¹ Given the widespread poverty among households with persons with disabilities, this often meant relying on poor-quality equipment, borrowing money, selling assets – or going without assistive devices altogether.³²

The absence of state-supported production or distribution mechanisms further reinforced dependency on humanitarian actors and charitable assistance. A 31-year-old man from Ghazni said:

*“We had problems in the Republic too, but at least we had a law that allowed us to raise our voices in accordance with the law. At that time, the Red Cross had a representative office in Ghazni, but it did not provide services to persons with disabilities, it only transported the injured to the Kabul Emergency Hospital. The Swedish Committee worked in the field of providing artificial limbs to the persons with disabilities, and educating them about their rights. The Swedish Committee’s services were comprehensive, starting at schools; their psychological services helped the disabled in almost every area.”*³³

Overall, access to assistive devices before 2021 was characterised by high dependency on NGOs, weak State ownership and severe geographical inequality.

5.5. Psycho-social Support

Psycho-social support for persons with disabilities remained one of the weakest components of service provision prior to 2021. Although decades of war, injury, displacement and poverty had produced widespread psychological distress, mental health services were neither systematically integrated into healthcare systems nor widely available. It should be noted that despite these limitations, psycho-social support for persons with disabilities before 2021 was far better than its nearly complete absence since 2021.

²⁹ KBL-KBL-F3-AJR- M-27082025

³⁰ KBL-QLQ-F3-HBN- M-26082025

³¹ PRW-BGM-F3-HZM-M-18082025

³² KII-F-PERSONS WITH DISABILITIESledNGO05062025

³³ GZN-CNL-F1-HT-M-03102025

Some international organisations implemented psycho-social support programmes, counselling services and community-based mental health initiatives, particularly in urban areas. However, these programmes were limited in scale, often project-based, and not sustained over time. Rural and remote areas received little to no psycho-social support (UK Home Office, 2025). Respondents rarely talked about this issue, as most of them hadn't received any assistance related to mental health and psycho-social issues. A 23-year-old woman, who has mobility-based disability and psycho-social health conditions, said:

*"I didn't receive any kind of mental health or psychiatric assistance – not before 2021 nor now."*³⁴

For many persons with psycho-social disabilities, social isolation, unemployment, stigma and dependency on family members caused psychological distress. Without structured psycho-social health services, individuals were left to cope on their own, often relying solely on religious practices or family support. In many cases, physical and psychological suffering went unrecognised or untreated, leading to depression, anxiety, emotional withdrawal, and increased vulnerability. A 43-year-old man expressed his emotion:

*"Keeping hope in God, the support of my family inspired me, though I was, and am, suffering a lot from this pain."*³⁵

Another respondent, a 44-year-old woman, made herself busy with an income-generating activity:

*"To prevent myself from depression and mental health problems, so as not to get worse, I started to work at a carpet-weaving workshop."*³⁶

The lack of institutionalised psycho-social services meant that mental health was treated as a secondary issue rather than an essential component of disability support.

In conclusion, across all service sectors before 2021, cost, distance, availability and social stigma emerged as the most significant barriers to access. Poverty limited the ability of persons with disabilities to travel, pay for treatment, purchase assistive devices or sustain education. Long distances to service centres, combined with inaccessible transportation, made even free services effectively unreachable for many. Availability of services was highly centralised and inconsistent. Entire districts lacked rehabilitation facilities, mental health services or vocational programmes. Where services did exist, they were often overwhelmed by demand or dependent on short-term donor funding.

These barriers interacted with social stigma, gender norms and weak governance to produce systematic exclusion. As a result, access to services before 2021 was not determined by rights or even needs but by location, resources and external support.

³⁴ SPL-AKD-F1-SF-F-06102025

³⁵ KBL-CHB-F3-QRD- M-23082025

³⁶ HRT-D9-F2-Naf-F-05092025

6. Key Barriers for Persons with Disabilities in Accessing Services Since 2021

Persons with disabilities in Afghanistan are facing overlapping social, economic and institutional barriers. These barriers are rooted in decades of conflict, widespread poverty, gender inequities, weak governance and cultural stigma. Interviews conducted across the country reveal that the daily lives of persons with disabilities are shaped by social exclusion, limited access to education and healthcare, economic marginalisation, restricted political participation, and invisibility in official data and policies. This section analyses these key barriers with illustrative testimonies, highlighting the structural and societal factors that exacerbate the challenges faced by persons with disabilities.

Since the political transition in 2021, persons with disabilities in Afghanistan have faced a sharp deterioration in living conditions, access to services and social protection. As section 5 highlighted, the pre-existing barriers related to poverty, weak infrastructure and limited service availability have been compounded by economic collapse, institutional restructuring and discriminatory policies since the return of the Taliban to power. These changes have disproportionately affected persons with disabilities, particularly women and girls, pushing many into extreme dependency, social exclusion and unrecognised dignity. The challenges they face are multi-dimensional, affecting daily life, livelihoods, safety and participation in society.

6.1. Social Stigma and Exclusion

Social stigma is a pervasive barrier that severely limits the inclusion and opportunities available to persons with disabilities. Across provinces, respondents consistently reported experiences of mockery, discrimination and exclusion in public, family and workplace settings. Such societal attitudes not only diminish self-confidence but also restrict access to education, employment and community participation.

Respondents shared their life experiences regarding stigma, with one woman with hearing impairment describing being ridiculed during public gatherings, which led to social withdrawal:

“Because we are deaf, sometimes our movements cause people to laugh ... that is why we rarely participate in gatherings.”³⁷

Similarly, a young woman emphasised the emotional toll of societal neglect:

“Pitying or ignoring our abilities – both are painful. Treat us like healthy people.”³⁸

Men also reported facing verbal abuse and social exclusion, illustrating that stigma is not gender-exclusive:

“When I go outside, people even call out to me, ‘Hey, lame man, where are you going?’”³⁹

Stigma often negatively affects psychological well-being, contributing to anxiety, depression and social withdrawal. One respondent explained that public interactions increase blood pressure due to the stress from societal reactions.⁴⁰ This evidence suggests

³⁷ HRT-D9-F2-Naf-F-05092025

³⁸ DS-D5-F2-Rz-F-1492025

³⁹ JZN-SBN-CNR-F1-SK-M-27082025

⁴⁰ HRT-D1-F2-AS-M-2292025

that social stigma not only isolates persons with disabilities but also directly impacts their physical and mental health.

Respect for human dignity is often absent. Persons with disabilities are frequently stared at, insulted or labelled with degrading terms. They are rarely given priority access to services and are often ignored or dismissed. These experiences contribute to psychological harm, social withdrawal and loss of self-worth. A 43-year-old woman said:

“I was engaged when I became disabled. My fiancé left me because of my disability. Though I was young, it shocked me a lot. I was hopeless because in Afghanistan it is extremely shameful for a girl to be left [when engaged]. Secondly, due to my disability and the existing culture at that time, I did not go to school. My father married me to a man who already had another wife.”⁴¹

Negative societal attitudes toward disability are widespread. Persons with disabilities are often viewed as objects of pity, divine punishment or economic burden. Terms such as “crippled” or “mad” are commonly used, reflecting deep-rooted misconceptions. Many community members believe persons with disabilities lack value or capability, leading to disrespect and marginalisation. A 23-year-old woman said:

“Whenever I go to any gathering or party, everyone asks me to sit in a corner. No-one would like to hear me or get my thoughts or ideas about something. I don’t have any problem at home, but outside people call us different names and we are humiliated in society.”⁴²

Stigma and discrimination continue to reinforce the social isolation of persons with disabilities, limiting their participation in community life and eroding their sense of dignity and self-worth. These attitudes not only deepen psychological distress but also normalise exclusion, making discrimination socially acceptable and difficult to challenge. Without targeted awareness efforts, legal protections and community-based inclusion initiatives, social stigma will remain a major barrier to the full and equal participation of persons with disabilities in Afghan society.

The current authorities also neglect the former regime’s persons with disabilities. One person emphasised that government assistance is sporadic and politically contingent:

“Once they gave me 9,000 AFN for one year ... They don’t want to support us because we are from the previous government.”⁴³

It must be noted that the judicial and military staff of the former regime avoid visiting the government for help for their own safety. The Taliban members confirmed receiving relatively frequent monthly support.⁴⁴

6.2. Gender-based Barriers

Women and girls with disabilities experience intersecting discrimination based on gender, disability and poverty. Cultural and gender norms restrict their mobility, education, employment and economic independence, while stigma and inadequate institutional support

⁴¹ KBL-DMKHN-F3-NZFA-F-19082025

⁴² SPL-AKD-F1-SF-F-06102025

⁴³ BGN-ANB-F3-HFZ-M-01092025

⁴⁴ KHO-DZ-MT-MK-M-04112025

increase their isolation and dependence. These barriers are particularly acute for women who acquire disabilities through conflict-related injuries or health complications.⁴⁵

Respondents highlighted forced dependence on families and exclusion from employment:

“Despite having a bachelor’s degree and work experience, I cannot obtain any position because of my disability and because I am a woman.”⁴⁶

In some cases, disability led to abandonment or coerced marriages:

“When my leg was amputated, my husband left me and married again ... My daughters and I struggle to survive.”⁴⁷

Social control and domestic oppression were cited repeatedly as compounding challenges. A woman from Parwan recounted:

“I am confused and helpless before God ... People do not support me and do not give me work.”⁴⁸

This research shows that women with disabilities face multi-layered discrimination: gender, disability and poverty intersect, restricting their agency and placing them at heightened risk of social and economic marginalisation. In the Afghan context, as stated in earlier studies such as The Rahyab Initiative Report (2025), these barriers are exacerbated by limited legal protections, conservative societal norms and inadequate institutional support.

Under the current government, restrictions on education, employment, and mobility further compound these disadvantages. Women with disabilities reported humiliation when accessing services without a male guardian, social shame and verbal abuse. A 27-year-old woman from Mazar described the risks associated with working outside the home:

“Despite of my disability, I work as a cleaner in a house to help my family. I have to go out every day from morning to evening. Men in the community complained to the community representative that ‘This woman is going out every day’. It puts my life at risk. I talked with the community representative about how I am working to feed my children and asked him not to complain about me to my husband, because if he does, my husband will not permit me to get out anymore. So he agreed not to talk with my husband.”⁴⁹

Social stigma and exclusion also have significant psychological consequences. Women with disabilities continue to carry out household responsibilities, but social stigma causes stress, trauma and isolation. A 23-year-old blind woman said:

“When I go somewhere, instead of feeling refreshed, my blood pressure goes up due to people’s reactions.”⁵⁰

Another woman from Herat, who is 36-years-old, said:

“People and children make fun of me with their looks and behaviour. They even changed our house name. My husband was a Mudir (Manager), so our house was called Mudir’s House, but now it’s changed to Lame House.”⁵¹

⁴⁵ 45 PRW-JSJ-F3-SHFA-F-07092025

⁴⁶ HRT-D2-F2-At-F-13092025

⁴⁷ HRT-D5-F2-ND-F-12092025

⁴⁸ PRW-JSJ-F3-SHFA-F-07092025

⁴⁹ MZR-CTL-F1-NB-F-09102025

⁵⁰ BDS-D5-F2-Rz-F-1492025

⁵¹ HRT-D5-F2-ND-F-12092025

These experiences demonstrate how gender-based restrictions, disability stigma, poverty and limited protection interact to undermine safety, dignity, mental health and independent living. As highlighted in The Rahyab Initiative Report (2025), limited legal protection, conservative social norms and inadequate institutional support further reinforce these inequalities. Gender-responsive policies, community awareness, accessible services and psycho-social support are therefore essential for protecting the rights and agency of women and girls with disabilities.

6.3. Lack of Access to Healthcare

Access to healthcare services for persons with disabilities is a critical part of their human rights, yet structural and logistical barriers severely limit it. Interviews reveal that geographical isolation, insecurity, poverty and disability-specific needs obstruct timely medical care and services for persons with disabilities.

War-related injuries were sometimes compounded by delayed or inadequate access to medical treatment, resulting in preventable complications and aggravated impairments. A man from Wardak recalled:

“Twenty days later, they took me to Kabul. My leg was amputated and my eye was never treated.”⁵²

Another respondent recounted the difficulties of reaching care while seriously injured:

“They took us on a motorcycle for hours ... I fainted several times. My leg was broken and later had to be amputated.”⁵³

These accounts illustrate how delays in emergency and specialist treatment can transform injuries into chronic impairments as well as aggravate existing impairments.

Persons with disabilities have the right to access healthcare on an equal basis with others, including services responsive to their disability-specific needs. However, as the overall data in this report demonstrates, geographical isolation, insecurity, poverty, inadequate transport and the limited availability of appropriate services create significant barriers to timely and affordable healthcare. For some, poverty alone makes healthcare inaccessible. As a woman with a mental disability explained:

“I have never gone to a doctor; my income is not enough even for bread.”⁵⁴

These barriers are particularly consequential for persons with disabilities, who may require ongoing medical care, rehabilitation, assistive devices, mental health services or other disability-specific support. The absence or limited availability of such services, particularly outside major urban centres, undermines their right to healthcare and can exacerbate existing impairments and dependency.

6.4. Lack of Access to Education

Educational services’ barriers were similarly pervasive. Regular education is largely inaccessible due to physical and attitudinal barriers. In most provinces, there are no specific

⁵² WDK-BSD-F3-ASD-M-01092025

⁵³ KBL-QLQ-F3-RHN-F-24082025

⁵⁴ KDR-DND-F3-KCH-F-17092025

educational centres for persons with disabilities, even at the provincial level, except for a few in the provincial capitals.⁵⁵

There are general restrictions in place by the current regime that affect all women and girls and there is no exception for women and girls with disabilities to access any form of educational services. Respondents reported school closures, inaccessible locations and restrictions on girls' education. One respondent from Kandahar said:

*"My school was on a hill ... Later, the Taliban came, and the gates were closed to girls."*⁵⁶

Chronic poverty, too, is a factor that limits children of persons with disabilities' access to education. For instance, a 39-year-old man said:

*"Because of extreme poverty and the poor economic situation, my children have also been deprived of education. They do not go to school ... At present, we are forced to make our children – our young ones – do hard labour. Right now, I am living a life of begging. Winter is approaching and we have absolutely no fuel, firewood or other means of heating in the house for the winter."*⁵⁷

These limitations impede skills development and future economic participation, perpetuating cycles of dependency and poverty.

6.5. Economic Marginalisation and Unemployment

Loss of income and employment is one of the most severe challenges faced by persons with disabilities since 2021. Employment opportunities have declined sharply across the country, but persons with disabilities have been disproportionately affected. Only a small number, primarily men who received vocational training under the previous government, have managed to sustain small businesses or informal work. For the majority, sources of income have disappeared entirely, and many are forced to rely on family (ICRC, 2023). One 39-year-old man said:

*"Two of my sons [children] work in a factory, where each of them is paid 4,000 AFN per month. That income only covers my electricity bill; it is not even enough to cover the house rent, let alone daily household expenses and living costs."*⁵⁸

Across the country, respondents emphasised that unemployment, poverty and dependency limit autonomy and create vulnerability. A man from Logar summarised the impact of these constraints:

*"I am illiterate and cannot walk. I cannot meet the needs of my family."*⁵⁹

A woman from Panjshir highlighted the compounded disadvantages:

*"I cannot do the activities I used to do ... I can't pay rent, and I am illiterate."*⁶⁰

According to a man from Paktia:

⁵⁵ KBL-QGH-F3-ZAK-F-17082025

⁵⁶ KDR-DND-F3-KCH-F-17092025

⁵⁷ ZBL-SJ-F1-AM-M-04102025

⁵⁸ ZBL-SJ-F1-AM-M-04102025

⁵⁹ LOG-PA-GA-AH-M-03112025

⁶⁰ PJR-RU-MT-ZS-F-07112025

“Persons with disabilities face more economic problems than others ... 60% suffer severe economic hardship.”⁶¹

Economic exclusion emerges as a central challenge, reinforced by limited education, inaccessible workplaces, employer discrimination and the physical constraints of disability. Many respondents rely on casual labour, charity or child labour to meet basic needs.

Many individuals who became disabled during earlier conflicts, including those injured while fighting alongside the Taliban, have been unable or unwilling to access disability allowances due to fear, insecurity or lack of clarity in registration processes. Reassessment and re-registration procedures introduced after 2021 have resulted in the exclusion of many previously registered beneficiaries. In several cases, individuals with partial or single impairments lost access to the annual disability allowance, while others who were previously ineligible were newly registered. This has created perceptions of discrimination and preferential treatment, particularly of former combatants affiliated with the current authorities. A 39-year-old man with multiple disabilities from Zabul said:

“After 2021, in the first year of the Emirate, they gave me 60,000 AFN. In the second year, they gave me 36,000 AFN. After that, they did not give me anything. When I called the head of the Ministry of Martyrs and Disabled Affairs and asked if he would give us the salary or not, he told me: ‘Go away, there is no money, there is no salary. You are a healthy person.’ After that, I did not ask again.”⁶²

A 69-year-old former attorney said:

“When I went to the Ministry of Martyrs and Disabled Affairs they made joke of me and said that former government’s attorney has come for his retirement salary.”⁶³

One 75-year-old former soldier said:

“I was a soldier during the Republic; I became disabled during that time. I was receiving my retirement salary of 100,000 AFN annually. I was able to receive proper treatment, but everything is changed since 2021. Now we don’t receive any kind of assistance. I went once to the Ministry of Martyrs and Disabled Affairs. They took my card and wanted to tear it up, and told me: ‘You are a war criminal, be thankful that we forgive you – and now you come shamelessly for us to assist you.’ So, I have never gone there again.”⁶⁴

The loss of income has forced many households to adopt negative coping mechanisms. Persons with disabilities, especially women, have become increasingly dependent on irregular humanitarian assistance. Others have sold personal valuable assets, such as jewellery or property, or borrowed money from relatives and friends to cover basic expenses such as rent and food. These economic pressures have also affected children in households with persons with disabilities, many of whom have dropped out of school and entered the child labour workforce to support their families.

Economic exclusion emerges as a central challenge, reinforced by limited education, inaccessible workplaces and employer discrimination. These testimonies demonstrate that without targeted economic programmes and workplace adaptations, persons with disabilities remain trapped in inter-generational cycles of poverty and social exclusion.

⁶¹ PKT-CNL-F1-GJ-M-23102025

⁶² ZBL-SJ-F1-AM-M-04102025

⁶³ FAR-D3-F2-AbW-M-19092025

⁶⁴ DKI-SH-MT-MA-M-12112025

6.6. Barriers to Participation in Community and Political Life

Persons with disabilities reported systemic exclusion from political, civic and community life. Physical, logistical and attitudinal barriers prevent engagement in governance, decision-making and public affairs.

One respondent emphasised the importance of economic empowerment for social integration:

*“The best way to live easily and cope with problems ... is work and duty. We are not beggars. We also have pride. There should be vocational schools for us.”*⁶⁵

Another participant highlighted the need for inclusive public awareness:

*“People with mental illness are not crazy ... They should be treated fairly and given opportunities to work.”*⁶⁶

These insights suggest that social and political marginalisation is both structural and attitudinal, requiring interventions that promote inclusion, awareness and empowerment.

6.7. Exposure to Exploitation, Neglect and Abuse

Persons with disabilities, particularly women and children and those with psycho-social or cognitive impairments, face heightened risks of neglect, domestic violence, economic exploitation and abuse. Dependence on care-givers, lack of reporting mechanisms and fear of retaliation prevent disclosure. Humanitarian protection and safeguarding mechanisms remain insufficiently disability-inclusive, with gaps in disability-disaggregated data, accessible reporting and complaints mechanisms, and consultation with OPDs limiting the identification and response to protection risks (International Disability Alliance, 2021).

A staff member of an organisation working with persons with disabilities indicated how children with disabilities are subject to exploitation by their own families:

*“Families use children with disabilities to receive aid and assistance, and this, in practice, results in children with disabilities not having normal access to learning and education. Their rights are being abused by their own family to begin with.”*⁶⁷

6.8. Lacking Registration for Services and Invisibility in Data and Policy

The systematic invisibility of persons with disabilities in official data and policy planning is one of the key barriers to understanding the depth of the issues they face and hence responding to their needs accordingly. Respondents reported that many individuals, particularly those with congenital disabilities or non-war-related impairments, are not registered with relevant government bodies, limiting access to social services, rehabilitation programmes and policy support. In recent years, even for war-related impairments, only the serious ones get registered; others are sent home without any form of aid or support. Some simply avoid registration due to fear of prosecution.

⁶⁵ BDS-D4-F2-D-M-1692025

⁶⁶ HRT-D4-F2-Hom-F-1092025

⁶⁷ KII-F-PERSONS WITH DISABILITIESledNGO05062025

This invisibility undermines targeted resource allocation and contributes to persistent neglect. The lack of accurate data and policy prioritisation perpetuates exclusion, leaving persons with disabilities isolated from and under-represented in social, economic and political decision-making.

6.9. Barriers to Mobility, Transport and Housing

Persons with disabilities face significant daily barriers in relation to mobility, transport and housing. Access to assistive and medical devices remains limited, costly and geographically concentrated, forcing many to live without adequate support. One 27-year-old woman shared her experiences:

“I go to the city every day for work, using local vehicles or walking. For transportation alone, it costs me 1,500 AFN per month. I face many difficulties in commuting because my prosthetic leg is very heavy and difficult to use. The house belongs to my mother-in-law, but my brothers-in-law have a problem with her living there ... my mental health is not good; I can’t sleep without medication.”⁶⁸

Mobility challenges are closely linked to housing and transportation barriers. In urban areas, rising rental costs have severely limited housing options for persons with disabilities. Landlords are often reluctant to rent to persons with disabilities due to perceptions that they are unemployed, poor or unable to pay rent consistently. This has increased housing insecurity and forced many persons with disabilities into overcrowded or substandard living conditions.

In contrast, while many persons with disabilities in rural areas own their homes, they face high transportation costs when travelling to urban centres for medical care, prosthetic repairs or administrative services. Many require continuous assistance from others for movement and daily activities. A 52-year-old man from Takhar said:

“I face many challenges daily. Transportation is one of the most important issues for me, as I can’t walk. My movement is difficult. My wife and children assisted me in getting to the hospital; however, the expenses were significant. One good thing is that I have my own house, though it is very old.”⁶⁹

Transportation costs are disproportionately high for persons with disabilities. Urban residents often pay higher fares than others because they need to travel with an additional companion or carry assistive devices. Public transport is largely inaccessible, lacking ramps, priority seating or trained staff.⁷⁰ As a result, many persons with disabilities restrict their movement, avoid public spaces and become increasingly isolated.

6.10. Barriers to Accessibility, Safety and Dignity

Persons with disabilities in Afghanistan face serious challenges related to safety, dignity and access to the community. Physical infrastructure rarely accommodates their needs, with limited ramps, uneven roads, inaccessible buildings and unsafe pathways. Public spaces, government offices, and service centres lack disability-friendly facilities, including accessible toilets and safe waiting areas. One 75-year-old man said:

⁶⁸ MZR-CTL-F1-NB-F-09102025

⁶⁹ TKR-CTL-F1-AH-M-06092025

⁷⁰ JZN-CNR-F1-ZQ-M-25092025

“Many transportation options are designed for able-bodied people and are not suitable for persons with disabilities. The lack of disability-friendly infrastructure – such as ramps, accessible pathways and smooth surfaces, combined with stairs, uneven ground and other physical obstacles – creates serious difficulties for persons with disabilities in moving around. I often do not participate in social gatherings, events or even family functions because most houses are multi-storey buildings and, in Afghanistan there are no elevators or lifts, which makes access extremely difficult for us as persons with disabilities.”⁷¹

The absence of inclusive planning and accountability mechanisms has left persons with disabilities exposed to ongoing neglect. Without targeted interventions, legal protections and inclusive policies, their safety, dignity and basic rights remain at risk. Addressing these challenges requires urgent attention to accessibility, anti-discrimination measures, gender-sensitive programming, and meaningful inclusion of persons with disabilities in decision-making processes.

In sum, the table below highlights the differences and changes before and after 2021 with regards to the overall system and its barriers for persons with disabilities. It has to be pointed out that, in addition to the existing barriers before 2021, the post-2021 period characterises not merely a decline in service availability but a qualitative shift from rights-based provision to discretionary, selective and politicised assistance.

Sector	Before August 2021 (Islamic Republic)	After August 2021 (Islamic Emirate)
Overall System	Fragmented but functioning system with limited State recognition of disability; partial legal framework and some institutional mechanisms; heavy reliance on NGOs.	System significantly weakened; reduced State capacity and co-ordination; increased reliance on humanitarian actors; shrinking civic space and reduced policy attention to disability.
Healthcare & Rehabilitation	Services existed through public hospitals and NGOs; highly centralised in urban areas; rural access extremely limited; long travel required; delays in treatment common.	Further deterioration in service availability; reduced funding and operational capacity; closures or scaling down of NGO services; increased barriers for women; access more restricted and uneven.
Assistive Devices	Provided mainly by NGOs (ICRC, Swedish Committee); good quality but limited coverage; long waiting times; urban concentration; high dependency on aid.	Continued dependency but with reduced coverage and funding constraints; supply disruptions; fewer operational centres; increased unmet need, especially in remote areas.
Psycho-social Support	Very limited and project-based; mostly urban; not integrated	Further decline and deprioritisation; mental health services even less accessible; increased psychological

⁷¹ DKI-SH-MT-MA-M-12112025

Sector	Before August 2021 (Islamic Republic)	After August 2021 (Islamic Emirate)
Education & Vocational Training	<p>into healthcare; largely neglected despite high need.</p> <p>Limited inclusion: some access in urban areas (mostly men); major physical, social and institutional barriers; women and girls severely disadvantaged.</p>	<p>distress due to crisis, poverty, and isolation.</p> <p>Severe restrictions on education, especially for girls and women with disabilities; reduced vocational opportunities; increased exclusion and drop-out rates; shrinking NGO programmes.</p>
Economic & Social Assistance	<p>Disability allowance (~60,000 AFN annually) existed but unevenly distributed; NGOs provided additional support; limited livelihood opportunities.</p>	<p>Allowance systems disrupted or inconsistent; reduced income opportunities; increased poverty; greater dependency on humanitarian aid; women face heightened exclusion from assistance.</p>
Geographical Access	<p>Services concentrated in Kabul and major cities; rural areas largely underserved; long-distance travel required.</p>	<p>Even greater geographical disparities; some services withdrawn entirely from remote areas; mobility constraints worsened due to economic crisis.</p>
Barriers (cost, distance, availability)	<p>Major barriers included poverty, long distances, weak infrastructure and limited service availability; access depended on location and resources.</p>	<p>Barriers intensified: rising poverty, reduced transport affordability, fewer services available; humanitarian access constraints further limit reach.</p>
Inclusion & Rights	<p>Disability recognised in policy but weakly implemented; some space for advocacy and rights-based engagement.</p>	<p>Reduced policy attention and advocacy space; disability increasingly invisible in decision-making; shift from rights-based to survival-based programming.</p>

7. Injustice Causing Impairment

The principal focus of this report is on the barriers that hinder persons with disabilities from exercising and enjoying their human rights. This chapter draws attention to a related but distinct human rights issue: the ways in which war, poverty, failures in public services and other structural conditions can themselves cause or intensify impairment. As Ribet (2011) argues, impairment can be understood as an **emergent** phenomenon, shaped by social, political, economic and environmental circumstances. ICESCR Article 12 further places conditions such as disease prevention and access to medical care within the sphere of human rights obligations.

In Afghanistan, this means looking not only at the barriers experienced by persons who have impairments, but also at how impairment may itself result from war, inadequate vaccination and treatment of childhood illness, gaps in maternal and prenatal care, and the absence of timely emergency treatment and rehabilitation. Attention to these processes expands the human rights analysis to the injustices through which impairment may be created or intensified, while maintaining the CRPD's central insight that environmental, institutional and attitudinal barriers are what turn impairment into exclusion and unequal enjoyment of rights (Committee on ESCR (2000).

7.1. The Social and Political Conditions Causing Impairment

In Afghanistan, impairment is shaped by decades of war, poverty, displacement and the disruption or absence of basic public services. As noted in the introduction, a human-rights analysis that focuses exclusively on equality once impairment has occurred, while overlooking the social and political conditions through which impairment may be created or intensified, is incomplete in the Afghan context. The situation in Afghanistan requires attention both to the barriers that persons with impairments encounter and to the structural and conflict-related conditions through which impairment itself may arise.

The interviews show the most direct connection in relation to armed conflict: 61% of respondents, men as well as women, reported that their impairment was directly caused by the prolonged war in Afghanistan. Mines, explosions, gunfire and other forms of violence have resulted in loss of limbs, visual impairment and other lasting physical injuries.

A 47-year-old man described how a mine explosion during his childhood caused multiple impairments:

*"I was injured by a mine explosion. It was the first period of the Taliban and I was just a child. I went out to see my brother when a mine exploded. I was injured from head to toe, so I lost one arm and a leg, and my eyes."*⁷²

The consequences of war are not limited to physical injury. Exposure to violence, fear, loss and prolonged insecurity can also cause or intensify psycho-social impairment. One mother described how her daughter was profoundly affected after witnessing violence against members of her family when she was eight years old.

*"My daughter was healthy until she was eight years old . When the Taliban was ruling in their first period, they dragged my husband and brother-in-law out to be tried. She witnessed that situation with all the women's screams and she got panicked. It had a profound effect on her mental health."*⁷³

⁷² GHR-CC-AS-AA-M-23112025

⁷³ HRT-D4-F2-Hom-F-1092025

Other testimonies show how psycho-social impairment may emerge through the cumulative effects of loss, insecurity and economic hardship rather than through a single event. A 50-year-old woman connected her own impairment and the psychological difficulties experienced by her family to bereavement, illness and continuing economic pressures:

“The unemployment of my sons, sickness of my husband, martyrdom of my father, brother and uncles – all these are the reasons for my impairment. Not only me, but all my family members have psychological problems. I go to homes and do cleaning and washing, you don’t know how difficult it is for me.”⁷⁴

War, however, is not the only pathway through which impairment is created. Afghanistan remains one of the countries where wild polioviruses are endemic, and disruptions to vaccination campaigns can expose children to a disease that may result in permanent paralysis.⁷⁵ Treatable childhood illnesses and infections may similarly result in lasting impairment because vaccination, medicines or timely treatment are unavailable. Conditions surrounding pregnancy, birth and early childhood also matter: inadequate maternal, and pre- and post-natal care, as well as malnutrition, can contribute to conditions that result in impairment (WHO, 2013; UNICEF, 2018; UNICEF, 2019).

These processes are closely connected to wider social and economic conditions. Poverty can determine whether treatment or rehabilitation is available at all, while distance, lack of transport, displacement and insecurity may make essential services impossible to reach. This report also highlights that roads, deteriorating infrastructure and inadequate workplace standards expose people to accidents that may result in injury and impairment.

Taken together, these experiences show that impairment in Afghanistan is not only a direct consequence of war; it can also be created or intensified through the conditions that prolonged conflict and poverty produce: interrupted vaccination, untreated childhood illness, inadequate maternal and pre- and post-natal care, unsafe environments, and the absence of timely treatment and rehabilitation. These are different pathways but they share an important feature: impairment may arise not only from an individual injury or condition, but also from circumstances shaped by social and political choices and failures, and from the immediate risks these create for communities.

7.2. Access to Immediate Health Services

Access to timely and necessary medical care is itself protected as part of the right to healthcare. In the context of this study, however, access to such services has a further human-rights significance: it can determine whether an injury or illness results in chronic impairment, and whether an existing impairment becomes more severe. In Afghanistan, the interviews show that this may depend on where a person lives, whether transport is available, whether treatment can be afforded, the security situation – and whether appropriate services exist at all.

For some respondents, the absence of treatment during childhood was directly connected to the development of impairment. One participant described being injured as a young boy, but being unable to obtain medical treatment because his family had no money and adequate services were not available where he lived:

⁷⁴ KBL-QLQ-F3-RHN- F-24082025

⁷⁵ WHO Regional Office for the Eastern Mediterranean. (n.d.). *Afghanistan: Polio eradication*. [WHO EMRO – Afghanistan Polio Eradication](#)

“My brothers took me home and gave me some medicine. My father was old and didn’t have the money to take me to the hospital. I was just a small boy; I couldn’t go to the doctor and had no money myself. My brothers did not want to spend money on me, and everyone said I would get better day by day. At that time, people didn’t go to the doctor; only those who had money went to Kabul. In the area where I lived, there was nothing to treat me.”⁷⁶

The testimony illustrates how poverty and the absence of nearby services can work in combination. Treatment may formally exist somewhere in the country, but remain realistically inaccessible to a person who cannot afford it or cannot reach it. Distance between rural communities and medical facilities, lack of transport and the costs associated with treatment thus affect not only access to services but, in some cases, whether an injury or condition develops into a lasting impairment.

Another respondent described particularly clearly how the absence of timely and appropriate treatment could transform an initially limited injury into a permanent and substantially more extensive impairment:

“I was injured during the civil war. The injury was not deep, but I couldn’t get access to better or proper treatment, so it became infected. Later, when I went to Kabul, the doctor confirmed it was infected and had turned black, and so it had to be amputated.”⁷⁷

The same relationship between available resources and access to treatment can be seen when specialised care is required. Respondents who had sufficient financial means sometimes sought treatment outside Afghanistan, particularly in Pakistan. One mother described years of efforts to obtain treatment for her daughter:

“My daughter was healthy until she was two years old, but after that, she stopped walking completely. She did not walk again until she was seven. After a long treatment, she recovered, but her leg became shorter. I took her to clinics in Herat and Kabul and they said her illness could not be cured. I did not give up. We went to Pakistan and started treatment there. Since she was three years old, she has been under treatment. I hope she gets better.”⁷⁸

Her experience also illustrates an important inequality in access to treatment. For some families, obtaining the treatment they seek requires travelling outside Afghanistan, an option available only to those with the financial resources and practical means to do so.

Access becomes particularly precarious during armed conflict. Urgent treatment may be delayed not simply because services are geographically distant or unaffordable, but because violence and insecurity make reaching them impossible. One respondent described the consequences after being wounded during fighting:

“After being wounded, my friends carried me about 1km to a hideout, and we remained surrounded for two days without food or water. Several of my friends were killed. After the fighting ended, the village militia transferred me to Kabul with other wounded people, but because of suspicion about my identity, I was tortured. I later escaped and was hospitalised for three months. Continuing treatment in my area was impossible, and after six months of severe infection, my leg was amputated at the district hospital.”⁷⁹

⁷⁶ KBL-GLD-F3-ARL-M-19082025

⁷⁷ KPS-NJR-F3-ABM-M-30082025

⁷⁸ FAR-D1-F2-Ng-F-1892025

⁷⁹ HRT-D14-F2-MS-M-2092025

These accounts reveal several different pathways through which lack of access to immediate and continuing medical services can cause or intensify impairment. Treatment may be unavailable because there is no facility nearby; it may exist but be financially inaccessible; specialised treatment may require travel outside the country; or conflict and insecurity may interrupt emergency and continuing care. In several of the testimonies, the crucial issue was therefore not only the original injury or illness, but what happened afterwards.

The experiences of respondents consequently make starkly visible the unjust creation or intensification of impairment. An injury that might otherwise have been treated can become permanent; an infection can progress until amputation is necessary; and the consequences of childhood illness can depend on whether a family has the resources and opportunity to obtain treatment. In this way, inequalities in access to immediate and continuing care become part of the social and political conditions through which disability and impairment is created or intensified in Afghanistan.



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8. Coping Strategies and Support System

While faith, family support and personal adaptation demonstrate important forms of resilience among persons with disabilities in Afghanistan, they should not be misconstrued as sustainable or sufficient solutions. In Afghanistan, however, prolonged conflict, insecurity, widespread poverty and political instability have resulted in the absence of such supportive frameworks. The State does not provide the systems, services, or physical and attitudinal change required for persons with disabilities in Afghanistan to even begin exercising and enjoying their most fundamental human rights. As a result, persons with disabilities are often compelled to develop their own survival strategies despite significant barriers. This over-reliance on individual resilience shifts responsibility away from institutions, masking systemic failures and normalising deprivation, rather than addressing the structural conditions necessary for meaningful inclusion and support.

Respondents' experiences show that strategies are shaped by the absence of formal State support. Coping mechanisms are therefore largely informal, family-centred, faith-based and adaptive in nature. One 63-year-old man said:

*“My family members support and take care of me anytime required. Everywhere I go, my son is with me, but I am sure and trust my neighbours and friends; if I ask for their support, they will never neglect me.”*⁸⁰

While these strategies demonstrate resilience, they also reveal the limits of endurance in the absence of systemic protection and inclusive services.

Persons with disabilities use different strategies to cope with the hardship of disabling barriers, as a visually impaired 26-year-old man said:

*“In the Holy Qur’ān, God says that when we remember Him, He grants us peace and brings hope into our lives. The source of my hope is faith in God and the belief that He will help me. I am reciting and reading the Holy Qur’ān, which gives me great inner peace, and its verses provide me with deep comfort and reassurance. And then, learning something new gives me hope and motivation in life. In addition, the support of my friends and family strengthens me to be hopeful.”*⁸¹

Almost all the respondents expressed their perspectives through the lens of their faith. They rely on prayer and place their hope in God. Education further strengthens this process by providing greater opportunities to build more meaningful and sustainable forms of resilience. A 35-year-old female poet said:

*“From the day that I sat in a wheelchair, I started to write poems, stories and novels. It gives me energy to live like a capable human. My family supports me too, especially my mother.”*⁸²

Community support is generally limited and uneven. In some areas, neighbours assist with transportation, small errands or emotional encouragement, particularly when social ties are strong.

A 35-year-old man from Paktia talked about his extraordinary educational journey:

*“I was encouraged by people around me – family, friends and neighbours – to continue my studies, and got my bachelor’s degree.”*⁸³

⁸⁰ PRW-SP-F3-ABJ-M-12082025

⁸¹ DKI-NI-GA-NS-F-12112025

⁸² HRT-D2-F2-At-F-13/09/2025

⁸³ PTK-CNL-F1-KW-M-2310-2025

However, many respondents report minimal or no community assistance, noting that neighbours are themselves struggling to meet basic needs. This reflects a broader pattern in which community solidarity exists in principle but is constrained by collective poverty and crisis conditions. A 50-year-old woman said:

*“My relatives and community members don’t have a better financial situation that would allow them to help us. There is no wealthy person in this community to help a needy one.”*⁸⁴

Charity, via *zakat* and *sadaqa*, and some humanitarian assistance, are the main and most necessary coping and supporting strategies for persons with disabilities to survive, specifically those who live below the poverty line. However, this form of support is unpredictable, seasonal and insufficient to address long-term needs. Reliance on charity reinforces dependency and does not contribute to sustainable coping or empowerment. A 32-year-old man from Badghis said:

*“My brothers, uncles, aunts and cousins are helping me; they give me their zakat, and my cousin, who is living abroad, used to send me 8000 AFN per month. But they can’t help me now as they are having financial problems themselves.”*⁸⁵

Economic crisis and/or insecurity, lack of access to services and social isolation are the most common challenges and were cited as things suffered from by all respondents. In response, individuals adopt strategies to focus on survival rather than advancement. These include reducing mobility to avoid harassment and costs, prioritising basic needs over healthcare, withdrawing from social spaces, and accepting exploitative or unsafe work conditions. A former soldier from the Republic time said:

“Lack of systematic strategies and support from a structured system or organisations have lowered persons with disabilities’ expectations, and normalised exclusion and deprivation from all basic rights for them. They stand on their faith and create resilience for themselves to cope with these barriers and maintain their hope under extreme conditions. These coping strategies are largely compensatory responses.”

The data in this report shows that persons with disabilities’ coping and resilience strategies are rooted in their faith, family support and their personal adaptation. These strategies are shaped by necessity rather than choice and cannot be considered an alternative for inclusive policies, social protections and access to basic humanitarian services. Without systematic strategies and support, resilience alone puts an unfair burden on individuals and families, deepening long-term psychological, economic and inter-generational costs for persons with disabilities in Afghanistan.

⁸⁴ PJR-RU-MT-ZS-F-07112025

⁸⁵ BDS-D4-F2-AbKh-M-2092025

9. Conclusion and Recommendations

Across Afghanistan, persons with disabilities are disadvantaged because of the compounded effects of social stigma, disability discrimination, gender inequality, lack of education and healthcare services, economic marginalisation, limited civic participation, and invisibility in policy frameworks. The testimonies illustrate that these barriers are mutually reinforcing: social exclusion limits access to work and education; economic marginalisation reduces healthcare access; and invisibility in policy aggravates exposedness to human rights abuse. Women and girls with disabilities are excessively affected, experiencing both societal and domestic oppression, while rural and conflict-affected populations face additional geographical and institutional barriers.

This study demonstrates that impairment and disability in Afghanistan are complex social phenomenon shaped by structural, cultural, and economic factors. Addressing these conditions requires multi-dimensional interventions: targeted social and economic programmes, inclusive education and health services, legal protections, public awareness campaigns, and comprehensive data collection. Only by tackling both the individual and systemic barriers can Afghan persons with disabilities have recognition of their inherent dignity, self-sufficiency, and equal participation in society.

This report provided a detailed snapshot of the situation of persons with disabilities in Afghanistan since the return of the Taliban to power in Afghanistan. Alongside the CRPD framework, with its focus on ensuring that persons with disabilities can exercise and enjoy all human rights on an equal basis with others, this report broadens the human rights perspective by also examining the unjust conditions through which impairment is caused and aggravated. Drawing on the ICESCR, it considers how conflict, poverty, inadequate healthcare and the absence of basic services can contribute to the creation or aggravation of impairment. This brings the causation of impairment into the human rights analysis without detracting from the CRPD's central concern with the rights, equality and inclusion of persons with disabilities.

The Taliban, as Afghanistan's de facto authorities exercising effective control over the territory and population, remain responsible for upholding Afghanistan's existing international human rights obligations, including those under the CRPD. The change in government does not extinguish the obligations of the Afghan State; international human rights bodies have expressly affirmed that the de facto authorities must respect and ensure the rights guaranteed by treaties to which Afghanistan is a party (CEDAW, 2025; UN Human Rights Council (2024).

For persons with disabilities, this means that, notwithstanding questions of international recognition, resource constraints or political circumstances, the de facto authorities have a continuing responsibility to prevent discrimination, ensure access to essential services and reasonable accommodation, protect dignity and autonomy, support rehabilitation and social protection, and enable the participation of persons with disabilities and their representative organisations in decisions affecting them. These responsibilities extend to all institutions exercising public authority and cannot be set aside on the grounds of non-recognition or political transition.

The strategic priorities directed toward UN agencies, national and international NGOs, government service providers, and broader humanitarian actors. These priorities emphasise opportunities for coordinated, disability-inclusive programming, joint needs assessments, improved data systems, expanded rehabilitation and assistive services within existing health structures, accessible humanitarian infrastructure, livelihood and skills development initiatives, sign-language dissemination, and strengthened monitoring through community-based volunteers.

These areas reflect responsibilities that formal actors can feasibly advance within current resource and mobility constraints.

Then, this report presented a set of general recommendations that relate to wider social and cultural conditions affecting persons with disabilities, including engagement with religious leaders, targeted community awareness through channels such as Friday sermons, radio programming, and storytelling, as well as gradual improvements in accessibility through charitable partnerships and stronger family and community support networks.

Separating these two categories enables clearer accountability: institutional actors can take forward structured responsibilities grounded in their mandates, while broader community-level efforts help create a social environment in which persons with disabilities can participate more fully.

The matrix below translates the findings into actionable priorities for de facto authorities and service providers, UN agencies, INGOs/NGOs, donors, humanitarian clusters, civil society organisations, community structures and persons with disabilities themselves. Timeframes are indicative and should be adapted to operational and security conditions.

Table 9A: Institutional and Humanitarian Strategic Priorities

Priority Action	Responsible/ Implicated Actor(s)	CRPD Basis	Timeframe	Resource Implication	Measurable Indicators
1. Establish coordinated disability-inclusive programming and joint needs assessments using common tools in Dari, Pashto and other relevant languages.	UN agencies; humanitarian clusters; INGOs/NGOs; relevant ministries/ service providers; OPDs	Arts. 4, 5, 31	0-12 months	Low-Moderate	Common assessment tool adopted; number of agencies using it; number of joint assessments conducted; data disaggregated by sex, age, impairment and location
2. Improve accessibility of humanitarian infrastructure , including WASH facilities, distribution points, health facilities and border/return facilities, through ramps, handrails, accessible queues and other context-appropriate modifications.	Humanitarian agencies; UN agencies; NGOs; site planners; relevant authorities; donors	Arts. 9, 11, 19	0-24 months	Moderate	Percentage of newly constructed/ rehabilitated facilities meeting accessibility standards; accessibility checklist incorporated into project design; number of facilities retro-fitted

3. Develop a phased disability information and mapping system, linked, where possible, to existing household and humanitarian data systems.	UN agencies; NGOs/INGOs; national statistical actors; donors; academic partners	Arts. 3, 4, 8 and 31	12-36 months	Moderate	Disability questions incorporated into surveys; number of provinces covered; frequency of data updates; anonymised datasets produced and shared
4. Integrate rehabilitation and assistive technology into existing health services, including district-level referral systems and pooled procurement of basic assistive devices.	Health service providers; WHO/UN agencies; NGOs; donors; relevant health authorities	Arts. 20, 25, 26	0-36 months	Moderate-High	Number of facilities providing rehabilitation/referral services; number of persons receiving assistive devices; functioning referral mechanism established; average referral time
5. Expand Afghan Sign Language access and communication accessibility, including dissemination of the existing lexicon, interpreter training and accessible information.	Education and health providers; universities; NGOs; UN agencies; OPDs; media actors	Arts. 9, 21, 24, 30	12-36 months	Moderate	Digital and offline sign-language resources available; number of interpreters trained; number of institutions using accessible communication; percentage of disability-related public information available in accessible formats
6. Establish skills-development and livelihood pathways aligned with local markets, including modular vocational training, co-operatives, savings groups and appropriate enterprise support.	NGOs; development actors; private sector; donors; OPDs; community organisations	Arts. 24, 27, 28	12-36 months	Moderate	Number/percentage of participants completing training; proportion entering employment/self-employment; number receiving livelihood/enterprise support; income change among participants

7. Establish community-based monitoring and referral mechanisms , with persons with disabilities and caregivers participating as monitors and community representatives.	NGOs; UN agencies; OPDs; community volunteers; service providers	Arts. 4(3), 19, 33	0-24 months	Low-Moderate	Number of trained monitors; percentage of monitoring teams including persons with disabilities; referrals completed; issues identified and resolved through monitoring
8. Institutionalise regular disability-focused data collection, analysis and learning , including periodic situational briefs and anonymised data-sharing across humanitarian and development actors.	UN agencies; NGOs; donors; academic institutions; OPDs	Art. 31	0-36 months and ongoing	Low-Moderate	Number of periodic briefs produced; datasets disaggregated by sex, age, impairment and location; number of agencies using findings to modify programmes

Table 9B: Rights, Social and Community-Level Priorities

Priority Action	Responsible/ Implicated Actor(s)	CRPD Basis	Timeframe	Resource Implication	Measurable Indicators
9. Ensure non-discriminatory and needs-based access to services and assistance , irrespective of political affiliation, social status or other characteristics.	De facto authorities; humanitarian actors; service providers; donors	Arts. 3, 5, 12, 25, 28	Immediate and ongoing	Moderate	Non-discrimination criteria incorporated into assistance systems; complaints recorded and resolved; evidence of equitable access across beneficiary groups
10. Engage religious scholars and Ulema to promote dignity, inclusion and non-discrimination through Friday sermons, religious	Religious scholars; community leaders; NGOs; OPDs	Arts. 5, 8; Preamble	0-24 months	Low	Number of religious leaders engaged; number of sermons/dialogues addressing disability inclusion; participant reach; changes in

gatherings and community dialogue.					reported attitudes where feasible
11. Implement community awareness and stigma-reduction initiatives through radio, storytelling, local dialogue and other culturally appropriate channels.	NGOs; media; community leaders; OPDs; local organisations	Arts. 5, 8, 19	0-24 months and ongoing	Low-Moderate	Number of campaigns/programmes delivered; audience reach; number of community dialogues; measurable change in disability-related attitudes in sampled communities
12. Promote accessibility in public and shared spaces , including markets, transport and community facilities, through incremental and low-cost improvements.	Local authorities; municipalities /community structures; businesses; charitable organisations; donors	Art. 9	12-36 months	Low-Moderate	Number of accessible public facilities; accessibility improvements completed; number of transport/service providers adopting accessibility measures
13. Strengthen family and community-based support mechanisms , including peer groups, care-giver support and referral links with service providers.	NGOs; OPDs; community volunteers; families; service providers	Arts. 19, 23, 26	0-24 months	Low-Moderate	Number of peer/support groups established; number of families reached; referrals made and completed; participant-reported improvement in access to support
14. Increase participation of persons with disabilities in humanitarian and development decision-making , including <i>shuras</i> , beneficiary committees, assessments and programme monitoring.	UN agencies; NGOs; community structures; donors; OPDs; relevant authorities	Arts. 4(3), 29, 33	Immediate and ongoing	Low	Percentage of committees/consultations including persons with disabilities; percentage of programmes documenting their participation; number of recommendations incorporated into programme design

Table 9C: Cross-Cutting Priority: Continuous Learning, Participation and Adaptation

Priority Action	Responsible/ Implicated Actor(s)	CRPD Basis	Timeframe	Resource Implication	Measurable Indicators
15. Adopt non-stigmatising and rights-based disability terminology in Dari, Pashto and other local languages across registration, communication, outreach and programme materials.	All humanitarian/development actors; media; authorities; OPDs	Arts. 3, 8, 21	0-12 months	Low	Standard terminology guidance developed; percentage of sampled programme materials compliant; staff trained in rights-based terminology
16. Establish continuous feedback mechanisms through which persons with disabilities can influence programme design, implementation, monitoring and adaptation.	UN agencies; NGOs; OPDs; donors	Arts. 4(3), 33	0-12 months and ongoing	Low-Moderate	Feedback mechanisms operational; number of responses received; percentage of programmes demonstrating changes based on disability-related feedback
17. Conduct periodic qualitative and intersectional research on social, economic, gendered, geographical and security-related barriers, including groups that are difficult to reach.	Universities; research institutions; NGOs; UN agencies; donors; OPDs	Arts. 6, 31	12-36 months and periodic	Moderate	Number of studies completed; geographical coverage; disaggregation by gender, age, impairment and location; evidence of findings informing policy/programming

18. Develop multi-actor approaches to disability inclusion rather than relying exclusively on State provision, particularly where State institutions lack capacity, legitimacy or willingness to provide non-discriminatory services.	UN agencies; NGOs; donors; OPDs; community organisations; private/charitable actors	Arts. 4, 19, 25, 28, 32	Immediate and ongoing	Moderate	Number of multi-actor initiatives; services maintained through diversified partnerships; percentage of programmes with non-State/community delivery mechanisms, where appropriate
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9.1. Priority Sequencing

Given the severe resource and mobility constraints in Afghanistan, implementation should follow a **phased approach**:

- **Immediate (0-12 months):** non-discrimination; accessible communication and terminology; participation of persons with disabilities; joint assessments; community monitoring; accessibility checklists; referral mechanisms; engagement with religious and community leaders.
- **Medium term (12-24 months):** rehabilitation and assistive services; accessibility improvements; livelihood and skills programmes; Afghan Sign Language dissemination; community support mechanisms; systematic disability data collection.
- **Longer term (24-36 months):** integrated disability information systems; sustained livelihood pathways; broader accessibility reforms; institutionalised research, monitoring and cross-sectoral disability inclusion.

Across all three phases, **persons with disabilities should be treated not only as beneficiaries but as rights-holders, participants and agents of change.** In line with Article 4(3) of CRPD, OPDs should be consulted and actively involved in decisions affecting them. This is particularly important in Afghanistan, where the limitations of State capacity, restricted civic space and declining international financing make a multi-actor approach essential.

The overarching objective should, therefore, be to move from **charity and episodic assistance towards rights-based inclusion, participation, accountability and agency**, while recognising the exceptional constraints of a protracted conflict and humanitarian crisis.

The study also warns against normative solutions whereby the responsibility for such implementation is left only to the State, which lacks legitimacy and follows discriminatory and restrictive rules, and/or international institutions whose funding is continually shrinking. In this context, it is crucial to focus on different strategic entry points to change attitudes and behaviours, and also on expanding the responsibility to other actors who can contribute to empower persons with disabilities and facilitate better services for them all.

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