SITUATIONAL ANALYSIS FOR YOUNG PEOPLE IN AFGHANISTAN

WITH PARTICULAR FOCUS ON SEXUAL AND REPRODUCTIVE HEALTH RIGHTS

2020

MAMTA HEALTH INSTITUTE FOR MOTHER AND CHILD, NEW DELHI, INDIA
### Abbreviations

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>AfDHS</td>
<td>Afghanistan Demographic and Health Survey</td>
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<td>AFN</td>
<td>Afghan Afghani</td>
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<td>AHS</td>
<td>Afghanistan Health Survey</td>
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<td>AIDS</td>
<td>Acquired immunodeficiency syndrome</td>
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<td>AIHRC</td>
<td>Afghanistan Independent Human Rights commission</td>
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<td>ALCS</td>
<td>Afghanistan Living Conditions Survey</td>
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<td>AMICS</td>
<td>Afghanistan Multiple Indicator Cluster Survey</td>
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<td>AMS</td>
<td>Afghanistan Mortality Survey</td>
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<td>ANC</td>
<td>Antenatal Care</td>
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<td>ANUDUS</td>
<td>Afghanistan National Urban Drug Use Survey</td>
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<tr>
<td>AYSRHR</td>
<td>Adolescents and Youths Sexual and Reproductive Health and Rights</td>
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<tr>
<td>BPHS</td>
<td>The Basic Package of Health Services</td>
</tr>
<tr>
<td>DALY</td>
<td>Disability Adjusted Life Year</td>
</tr>
<tr>
<td>DHS</td>
<td>Demographic and Health Survey</td>
</tr>
<tr>
<td>EPHS</td>
<td>Essential Package of Health Services</td>
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<tr>
<td>FP</td>
<td>Family Planning</td>
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<td>FSW</td>
<td>Female Sex Workers</td>
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<td>GBV</td>
<td>Gender-Based Violence</td>
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<td>GPI</td>
<td>Gender Parity Index</td>
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<td>HDI</td>
<td>Human Development Index</td>
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<tr>
<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
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<tr>
<td>IBBS</td>
<td>Integrated Bio-Behavioral Surveillance</td>
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<tr>
<td>IDP</td>
<td>Internally Displaced People</td>
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<td>IDU</td>
<td>Injecting Drug Users</td>
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<tr>
<td>IFA</td>
<td>Iron and Folic Acid</td>
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<tr>
<td>IPV</td>
<td>Inter-Personal Violence</td>
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<tr>
<td>MoE</td>
<td>Ministry of Education</td>
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<tr>
<td>MoPH</td>
<td>Ministry of Public Health</td>
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<tr>
<td>MoWA</td>
<td>Ministry of Women’s Affairs</td>
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<tr>
<td>MSM</td>
<td>Men Sex with Men</td>
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</tbody>
</table>
MTCT : Mother to child transmission
NAPWA : National Action Plan for Women of Afghanistan
NGO : Non-Governmental Organization
NMHS : National Mental Health Strategy
NNS : National Nutrition Survey
PNC : Post-natal Care
PRISMA-ScR : Preferred Reporting Items for Systematic Review and Meta-analysis extension for scoping review
RMNCAH : Reproductive, Maternal, Newborn, Child and Adolescent Health
SBA : Skilled Birth Attendant
SRH : Sexual and Reproductive Health
SRHR : Sexual and Reproductive Health Rights
STI : The Sexually Transmitted Infections
TA : Technical Assistance
TT : Tetanus Toxoid
UN : The United Nations
UNDP : United National Development Program
UNFPA : United Nations’ Population Fund
UNHCR : United Nations High Commissioner for Refugees
UNICEF : United Nations Children’ Fund
USAID : United States Agency for International Development
USD : United States dollar
WB : World Bank
WHO : World Health Organization
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BACKGROUND

Afghanistan faces a number of challenges ranging from internal conflicts to economic decline; poor governance and management and lack of accessibility to basic services in health, food, education, housing, and other basic human needs to its citizen (1). Afghanistan with a population of 37.2 million in 2018 had a Human Development Index (HDI) of 0.496 and an HDI ranking of 170 out of 189 nations (2). Moreover, youth literacy is low with 62% for young men and 32% for young women) and ensuring decent jobs to the young population remains one of the biggest problem in the country (3).

Despite numerous challenges, Afghanistan has been internationally acknowledged for its efforts to improve the health of its population over the last 15 years. Health system of the country was remodelled by developing and implementing the Basic Package of health Services (BPHS) and Essential Package of Health Services (EPHS) in 2004 which resulted in health gains particularly improved maternal, new-born, and child health outcomes in the country. Afghanistan’s innovations and investments in the health sector have contributed laying down the foundation for the continued socio-economic development and the achievement of Afghanistan’s National Development Goals (4). However, historically less attention been devoted to understanding and meeting the specific needs and preferences of young people, however in 2013 steps were made to this aim with the development of the country’s first National Youth Policy (5). This negligence partly emerges from lack of data on specific health needs of young people, however also points to the need for mainstreaming of adolescent and youth issues in national health strategies (6).

Afghanistan’s young age structure

Afghanistan has a young age structure where about 63.7 percent of the population is under 25 years of age (3) and around 46.1 percent is below age 15 (7). Young people by UN are referred as the combination of adolescents (10-19 years) and youth (15-24 years), with the ages of 10-24 years. However, Afghanistan National Youth Policy defined ‘youth’ as a person who falls between 18-35 years of ages. Afghanistan’s age structure will soon form a ‘youth bulge’, reflecting a steep ‘pyramid’ age structure whereby a large cohort of young people is slowly emerging (3). But, the young people are still facing challenges with respect to basic health services, education, employment and deep-rooted gender inequalities (6). Steering efforts towards addressing these may contribute towards a greater demographic dividend.

From developmental perspective, focusing on the health of young population is vital for the nation. However, most of the times, countries often do not recognize the significance of young people in social and economic progress as a result of which dedicate too less resources to harness their full potential. This dearth of investment diminishes national growth and progress. To address this, investments in young people’s health, education and nutrition are pivotal. Young people are vulnerable and have complex health needs including adequate nutrition, positive mental health, education and sexual and reproductive health rights. In Afghanistan, girls and young women in particular face movement restrictions and have less control over key decisions in their lives than men. They are vulnerable to poor education and health, child marriage, early pregnancy, violence, sexual abuse and exploitation. Moreover, young women’s risk of dying from pregnancy and birth-related complications is high (6). In Afghanistan, boys tend to gain greater freedom as they enter adolescence and moves towards adult life, and that bring pressures to contribute to household incomes which is identified as a leading cause of school drop outs, exploitative and hazardous work, recruitment by armed groups and migration. Additionally Young men are also vulnerable to exploitation and sexual abuse (8). Another challenge
faced by Afghan youth is drug addiction contributed in part by low educational level and unemployment.

In particular, the reproductive and sexual health decisions young people make today will affect the health and well-being of themselves, their communities and of their countries for decades to come. Absence of extensive data and evidences on the health need and preferences of adolescents and young people, it is difficult to measure the gravity of the situation. Though MOPH, Afghanistan has developed the first National Health Strategy and Action Plan for Young People (2015-2019) (9), no information on it implementation is available. So, as a first step to address the aforementioned challenges, Afghanistan requested for support from the “WHO AYSRHR TA Coordination Mechanism” to review the adolescent/youth health situation in the country, with particular attention to the SRHR needs of young women/couples before, during pregnancy and after birth, and provide recommendations for how they could be addressed. This will be accomplished through a situational analysis consisting of two distinct components a desk review and landscape analysis.

The specific objectives of this review are as follows:

1. To identify the main health problems affecting young people (e.g. mortality, morbidity, and disability), focusing on SRH and other related health problems (e.g. nutrition, mental health, injuries)
2. To study the extent of health related behaviours that underlie adolescent health problems, in the present.
3. To explore the determinants of adolescent health problems and health-related behaviours (e.g. risk and protective factors; social values and norms, including gender norms that have an impact on the health of girls and boys: levels of child marriage, educational opportunities).
4. To understand the context of adolescents’ lives (e.g. sociocultural and environmental), at various ecological levels and in different settings (e.g. schools, health services, work)
5. To identify major gaps in the data available planning and monitoring interventions for young people.

METHODOLOGY

Analytical framework was developed to address the desk review objectives as stated above. The review addresses adolescent and youth’s sexual and reproductive health needs, with a special focus on young women/couples before, during pregnancy and after birth. In addition, it addresses six thematic areas which are related to Sexual and Reproductive health (SRH); mental health, nutrition, maternal health, violence, substance use, and education.

Data collection

The data was collected through a systematic search of secondary data from scientific data bases and grey literature. The review was developed and reported in accordance with Preferred Reporting Items for Systematic Review and Meta-analysis extension for scoping review (PRISMA-ScR) guidelines. A systematic search strategy was developed using the keywords, identified through literature search and further consultation with subject experts. A web-based search was conducted using the relevant databases PubMed, Medline, and PsycINFO to review the peer reviewed articles and retrieve the citations. Grey literature was also reviewed to have a broader understanding of the country context in relation to its socio-cultural environment, national laws and policies and situation of adolescents.
through various sources such as Ministry of Public Health and other government websites, national documents, reports, bilateral, multilateral agencies, Google and NGOs working in Afghanistan.

Inclusion criteria: The articles published in English, published between 2010 and 2020 and the study that included human subjects and the key terms included in the search are stated below in Table 1.

<table>
<thead>
<tr>
<th>Population</th>
<th>Setting</th>
<th>Thematic area</th>
</tr>
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<tbody>
<tr>
<td>Young people, Youth, Young</td>
<td>Afghanistan,</td>
<td>Sexual and Reproductive health- sex, sexual, reproductive, health, right,</td>
</tr>
<tr>
<td>people, Young couples, Adolescents, Teenagers, Teen</td>
<td>Afghani, Afghan</td>
<td>menarche, menstruation, premarital, puberty, HIV, STI, contraceptive, family planning</td>
</tr>
<tr>
<td></td>
<td>Afghanistan,</td>
<td>Maternal health- maternal, mother, pregnancy, antenatal, prenatal,</td>
</tr>
<tr>
<td></td>
<td>Afghani, Afghan</td>
<td>perinatal, ANC, PNC, postnatal, delivery, conception, preconception, birth, abortion, miscarriage</td>
</tr>
<tr>
<td></td>
<td>Afghanistan,</td>
<td>Gender based violence- violence, injury, accidents, domestic violence, abuse</td>
</tr>
<tr>
<td></td>
<td>Afghani, Afghan</td>
<td>Nutrition- Nutrition, vitamin, IFA, anemia, calcium, diet, food, meal</td>
</tr>
<tr>
<td></td>
<td>Afghanistan,</td>
<td>Mental health- mind, suicide, suicidal ideation, suicidal attempt, depression, stress, mental health, trauma, distress, counseling, conflict, anxiety</td>
</tr>
<tr>
<td></td>
<td>Afghani, Afghan</td>
<td>Substance use- substance abuse, addiction, tobacco, drug use</td>
</tr>
<tr>
<td></td>
<td>Afghanistan,</td>
<td>Education- literacy, education, school, academic, media, digital, internet</td>
</tr>
<tr>
<td></td>
<td>Afghani, Afghan</td>
<td>Vulnerable populations- refugee, migrant, terrorist, displaced, religion, injecting drug users, sex workers, drug addicts</td>
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</tbody>
</table>

Table 1 Key terms identified for the database search

Data screening and synthesis
The citations were then downloaded from the three databases and imported to EndNote library to eliminate the duplicate articles. Later the final number of citations were exported to endnote for further screening. After removing the duplicates from all three databases a total of 1509 citations were identified for further steps. After which all articles were subjected to screening for inclusion against a set of predetermined criteria (as mentioned above). We screened all the titles and abstracts to identify most appropriate studies for full text screening. At the final stage a total of 38 research articles were identified for data extraction and synthesis (Figure 1).

Data analysis
A thematic narrative synthesis of included articles was done for summarizing the finding from the studies (Annexure I). All the data from scientific databases and the grey literature was collated for further analysis. Where ever possible all the data was analyzed and disaggregated by age (10-14, 15-19, 20-24 years) and sex. The data has been represented through urban/rural, education and socio-economic status. The data was identified for the vulnerable groups. Gaps were identified in the available data from the review.
## FINDINGS OF THE DESK REVIEW

### TABLE 2 Demographic Data of Young People in Afghanistan

| Indicator                                                      | Value | Unit   | Source         |
|                                                               |       |        |               |
| Population among 15-24 years                                   |       |        |               |
| Male                                                          | 19.5  | Percentage | ALCS 2016/17 |
| Female                                                        | 19.2  | Percentage | ALCS 2016/17 |
| Urban                                                         | 19.8  | Percentage | ALCS 2016/17 |
| Rural                                                         | 22.5  | Percentage | ALCS 2016/17 |
| Kuchi (Nomads)                                                | 18.7  | Percentage | ALCS 2016/17 |
|                                                          | 16.4  | Percentage | ALCS 2016/17 |
| Total Population                                              |       | Percentage | ALCS 2016/17 |
| Male                                                         | 51.0  | Percentage | ALCS 2016/17 |
| Female                                                        | 49.0  | Percentage | ALCS 2016/17 |
| Urban                                                        | 23.8  | Percentage | ALCS 2016/17 |
| Rural                                                        | 71.2  | Percentage | ALCS 2016/17 |
| Kuchi (Nomads)                                                | 5.0   | Percentage | ALCS 2016/17 |
| Disability prevalence rate among 10-14 years                  |       | Percentage | ALCS 2016/17 |
| Male                                                         | 1.2   | Percentage | ALCS 2016/17 |
| Female                                                        | 1.1   | Percentage | ALCS 2016/17 |
|                                                          | 1.2   | Percentage | ALCS 2016/17 |
| Disability prevalence rate among 15-19 years                  |       | Percentage | ALCS 2016/17 |
| Male                                                         | 1.6   | Percentage | ALCS 2016/17 |
| Female                                                        | 2     | Percentage | ALCS 2016/17 |
|                                                          | 1.1   | Percentage | ALCS 2016/17 |
| Disability prevalence rate among 20-24 years                  |       | Percentage | ALCS 2016/17 |
| Male                                                         | 2     | Percentage | ALCS 2016/17 |
| Female                                                        | 2.2   | Percentage | ALCS 2016/17 |
|                                                          | 1.9   | Percentage | ALCS 2016/17 |
| Disability prevalence rate in total population                |       | Percentage | ALCS 2016/17 |
| Male                                                         | 3.2   | Percentage | ALCS 2016/17 |
| Female                                                        | 3.1   | Percentage | ALCS 2016/17 |
| Urban                                                        | 3.2   | Percentage | ALCS 2016/17 |
| Rural                                                        | 4.3   | Percentage | ALCS 2016/17 |
| Kuchi (Nomads)                                                | 2.8   | Percentage | ALCS 2016/17 |
| Disability Gender Parity Index (GPI) among 20-24 years        | 0.84  | Index | ALCS 2016/17 |
| Disability Gender Parity Index (GPI) among total population  | 0.98  | Index | ALCS 2016/17 |
| Youth unemployment rate                                       |       | Percentage | ALCS 2016/17 |
| Male                                                         | 30.7  | Percentage | ALCS 2016/17 |
| Female                                                        | 24.3  | Percentage | ALCS 2016/17 |
| Urban                                                        | 47.4  | Percentage | ALCS 2016/17 |
| Rural                                                        | 39.4  | Percentage | ALCS 2016/17 |
| Kuchi (Nomads)                                                | 29.6  | Percentage | ALCS 2016/17 |
|                                                          | 13.3  | Percentage | ALCS 2016/17 |
| Total unemployment rate                                       |       | Percentage | ALCS 2016/17 |
| Male                                                         | 18.3  | Percentage | ALCS 2016/17 |
| Female                                                        | 41.0  | Percentage | ALCS 2016/17 |
| Urban                                                        | 26.5  | Percentage | ALCS 2016/17 |
| Rural                                                        | 24.0  | Percentage | ALCS 2016/17 |
| Kuchi (Nomads)                                                | 12.3  | Percentage | ALCS 2016/17 |
| Total fertility rate (12-49 Yrs)                              |       | Children per Women | AHS 2018 |
| Urban                                                        | 5.1   | Children per Women | AHS 2018 |
|                                                          | 4.3   | Children per Women | AHS 2018 |
Since the country has a very young age structure (7) and poor health and development indices, including disability rate, gender parity index, life expectancy, mortality rate, substance use, it is crucial to invest in their health and development and address the needs of the young population through appropriate policies and strategies with a gender perspective (7).

<table>
<thead>
<tr>
<th>S.No</th>
<th>Policy/Strategy</th>
<th>Year</th>
<th>Implementing Organisation</th>
<th>Theme/Issues addressed</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>(RMNCAH) Strategy</td>
<td>2017-2021</td>
<td>MOPH</td>
<td>This strategy aims to improve the health, nutritional status, and well-being of women, mothers, newborns, children, and adolescents throughout Afghanistan. The strategy seeks to avert preventable deaths and morbidity and treat patients’ conditions by ensuring that appropriate preventive and curative information and services are universally available to every family and community.</td>
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<tr>
<td></td>
<td>The National Child and Adolescent Health Strategy</td>
<td>2009-2013</td>
<td>MOPH</td>
<td>Integrated package of all the priority strategic interventions for child survival, adolescent health, establishment of the national and provincial maternal and child health committees.</td>
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<tr>
<td>4.</td>
<td>National Youth Policy</td>
<td>2013-2014</td>
<td>Deputy Ministry of Youth affairs</td>
<td>Systematically meets the needs of youth through an inclusive approach, involving all relevant governmental and non-governmental entities, and to design and implement short-, medium- and long-term strategies and programmes to develop youth talents, skills and potential in the economic, social, cultural and political spheres.</td>
</tr>
<tr>
<td>6.</td>
<td>National Gender Strategy</td>
<td>2012-2016</td>
<td>MoPH</td>
<td>To improve the health and nutrition status of women and men equitably and to improve gender equity within the health sector. The strategy focuses on reproductive health, child, and adolescent health.</td>
</tr>
</tbody>
</table>

**Education**

Due to thirty years of conflict and political unrest, Afghanistan has faced a huge challenge to maintain its education system in terms of staffing, premises, curricula and student attendance. Girls were even prohibited from attending schools during the Taliban rule until 2001. In addition to girls, disadvantaged children, particularly children with disabilities, children in remote rural areas and from poor families, and ethnic minorities have had lower enrolment rates and higher rates of repetition and drop out before educational completion (10). With the fall of Taliban’s rule in 2001, a nationwide reconstruction process was being executed with considerable support from the international community. According to the Ministry of Education (MoE), in 2001, only 1 million children (almost all boys) were enrolled in schools, however it grew to over 8.6 million in 2013 of whom 39% were girls. Furthermore in 2015, the Ministry recorded 9.2 million enrolled students. As per the ALCS (2016-17) estimated youth literacy rate is 53.6. Male and female youth literacy rate in the same year was 68.2 and 38.7 respectively which shows almost a difference of 50%. The similar trend could be seen in the average levels of education attainment where male have an average of 9.7 years in the school and
females have 5.6 years (7). Majority of the older females have no education, however the proportion reduced to half for males (Figure 2).

**Figure 2 Level of Education Attainment in different Age-Groups among Young People**

According to the Education sector Analysis report 2016 (11), the quality of education in Afghanistan is perceived to be quite low and is affected by multiple factors including poor school facilities; inadequate teacher qualifications; inadequate and insufficient learning materials and textbooks, inefficient provision and untimely distribution of textbooks and poor school management. Moreover, conflicts strengthen numerous cycles that worsen overall vulnerability by increasing poverty, child labour and early marriage for girls, thereby preventing vulnerable children from accessing quality education (12). Afghanistan health survey 2018 reported that only 65.6% of children between 10 - 14 years of age had attended school (13). To respond to this situation, one step taken by the MoE is to identify a new series of quantitative indicators to monitor progress in the development of the education system and in education achievements in the latest National Education Strategic Plan (2017-2021)(7).

Education is an integral part of young peoples’ life affecting their choices related to different aspects of health. It has been reported that women with higher education tend to delay their marriage (14)
first conception (15), utilizing ANC (16) and PNC services (17) have facility delivery (18) and higher odds of using contraceptives (19,20). Additionally, educated women are more likely to enjoy autonomy in their life (21). Hence for a country like Afghanistan education quality, equity, and access remain urgent national development concerns.

Mental Health
As per WHO, over 2 million of Afghanistan population is estimated to suffer from a mental health problem. It is estimated that most Afghans suffer from some level of stress disorder because of the long period of conflict. Additionally, over the last decades, mental health diseases have not been addressed in Afghanistan and hence little is known about its pattern (22).

In conflict areas like Afghanistan, mental health research has predominantly focused on war-related trauma and post-traumatic stress disorder instead of broader set of predictor and outcome variables. A longitudinal study showed that stressful family conflict, traumatic domestic beatings and stressful family violence were reported as notable potential factors affecting mental health (23). Also, suicidal rate, which is one of the major indicators of mental health, has also not been captured and there is lack of evidence on the rate in Afghanistan (24). As mentioned above large-scale surveys have shown a broad gamut of mental health problems in the adult population—including anxiety, depression and post-traumatic stress. Moreover, substance use among male population reported in Afghanistan is also high as 41% of male aged 20-24 years and 28.7% of male aged 15-19 years uses tobacco and 1.9% male aged 20-24 years and 0.7% male aged 15-19 years reported to have use any sort of drug (25).

Although Afghanistan has had a national mental health policy, plan and legislation since 1987 which addresses the main mental health issues, the overall evidence related to its implementation is weak. Moreover, there is no systematic budget allocation for mental health (26). MOPH initiated vital steps towards effective and efficient mental health services to the population by incorporating mental health as a component in BPHS in 2003, launching the National Mental Health Strategy (2009-2014) (27) and upgrading the same in the year 2019 (28). In the NMHS a separate strategy has been developed to address mental health needs and well-being of adolescent and vulnerable populations. However, in the latest strategy, pregnant and post-partum women have also been included. As majority of the policies and strategies recently added adolescent as a distinct group, a lacuna is found for evidences on their current mental health related conditions specially for adolescents and young people.

Mental health and SRH forms integral part of overall health and well-being of young people. Globally self-harm has been reported as the second leading cause and third leading cause of death among girls and boys of age 15-19 years respectively (29).

Mental health status plays important role in determining and shaping the SRH behaviour and vice-versa. Research have shown that individuals with mental health illness tend to have more sexual partners over lifetime, limited use of contraceptives and have higher chances of unplanned pregnancy which may lead to greater risk of STIs including HIV and AIDS (30). Moreover, depression during pregnancy or after child-birth is experienced by almost 20-40% of women in developing countries. (31). For overall growth and prosperity of young people in the country, it is crucial to address the overall health which includes physical as well as their mental health.
Substance use

Substance use is a growing concern among young men. Tobacco use among ever-married men aged 15-19 years and 20-24 years is 28.7% and 41%, respectively, while drug use is 0.7% and 1.9% in the corresponding ages (AfDHS 2015). The Afghanistan National Urban Drug Use Survey 2015 (ANUDUS) reported 2.3 percent of those aged below 15 tested positive for drug use. Based on available data about the context of drug use in Afghanistan, there appears to be a recent shift from smoking to injecting use, mainly among young people. Cottler and colleagues estimated that, after direct age standardization, 5.1% of the Afghan population (7.2% of men and 3.1% of women) either reported use or had biological evidence of recent use of drugs such as opium, heroin, pharmaceutical opioids, and cannabis (32). Unemployment was found to be a significant predictor of injecting drug use.

Gender-based violence

Gender-based violence remains a challenge to promote human rights for women in Afghanistan (33). The United Nations Gender Inequality Index ranks Afghanistan last out of 169 nations (34). Globally 1 in 3 women have experienced physical or sexual violence but in Afghanistan 1 in 2 ever married women have experienced physical violence since age 15.

According to the recent AfDHS, the percentage of young women experiencing physical, sexual and emotional violence committed by their husband in the age group of 15-19 and 20-24 years in Afghanistan is quite high (Figure 3) (25). Whereas, only 0.6% (15-19-year-old) and 0.7% (20-24-year-old), ever married women who committed physical violence against their husband. On the other hand, there is violence against men too, as IPV is the eighth leading cause of death and DALY in men aged 15-49 years (35). Inter-personal violence can lead to serious consequences for the victims such as mental health issues (including attempt of suicide), injuries, HIV/STIs and unwanted pregnancies (for women). Considering the disproportionate burden of violence on women it is important to note that only 18% (15-19-year-old) and 17.2% (20-24-year-old) sought for help to stop the violence which needs critical attention (25). As according to the Afghanistan Independent Human Rights commission (AIHRC) the cases of violence against women have increased by 11.7% in 2018 (36).

GBV in Afghanistan is exacerbated due to multiple issues at the individual level (poverty, illiteracy, unemployment), inter-personal (unequal relations due to gender inequality), community level (lack of support to victims, lack of security, lack of decisive treatment to offenders, restrictive access to justice for women) and societal level (weak governance, corruption, continued culture of impunity) (37). Even though, the government of Afghanistan adopted the Elimination of Violence against Women legislation by presidential decree in 2009 (38) and provided a framework for addressing the challenge.
After which cases involving violence against women have been constantly reported but are rarely prosecuted\(^1\),\(^2\).

In many ways the harmful traditions in Afghanistan are self-perpetuating and entrenched in gender inequality and social norms that restrict women’s agency in society, within their own communities and families. According to the AfDHS, 94% of the physical violence among ever married women was perpetrated by the husband. The deep rooted gender inequality and social norms are evident from the data that shows that 80.7% of the 20-24 years old women agree that a husband is justified in hitting or beating his wife for specific reasons\(^3\) (25) which signifies that there is considerable amount of under reporting of cases of violence. According to AIHRC survey, 97.4% of the cases of violence occurred within households, and the rest of the cases were reported with violence in the street or alley, workplace, hospital, educational institutes, detention centres or in jail (37). Additionally, there is evidence that domestic and family violence is strongly linked to violence against children including adolescents and are exacerbated in contexts of armed conflict and disasters (39). But, in Afghanistan there is lack of data on violence by parents. This persists in spite of a range of government programs and policies to protect women and children.

**Child marriage**

Child marriage is illegal but persists at rates that suggest at least one in three young girls will be married before they turn 18 (40). There are gender differences in the legal age for marriage, it is 18 years for boys and 16 years for girls (15 years for adolescents with fathers’ consent or consent from the court). According to the AfDHS, 34.8% of women aged between 20-24 were married by age 18 and 8.8% of the women between 20-24 years were married by age 15 (25). There is evidence from various studies that show illiteracy or low level of education, increased poverty, traditional customs/practices such as baad\(^3\) or baadal\(^4\), limited awareness of the risks associated, absence of effective system to register marriages and lack of law enforcement all contribute to the causes of child marriage in country (40–42)

Child marriage puts adolescents at the risk of unintended pregnancy, early childbirth which doubles the risk of a spontaneous abortion and can result in low birth weight, higher rates of stillbirth and obstetric fistula (43,44). Findings from a UNFPA report revealed that the prevalence of obstetric fistula is estimated to be 4 cases per 1000 among women in the reproductive age in Afghanistan (45). Large age differentials are characteristic of such marriages (46) which further reduce decision making power of the wife in view of the gender norms.

Child marriage is associated with dropping out-of-school or vice versa, which is related to multiple factors such as poverty, the low status afforded to women, and social norms that lead parents to place little value on investing in girls and their education (47). There were wide gender differences in school attendance among those aged 5–24 years, 19.2% of girls dropped out due to marriage, compared to 2.9% of boys (25). According to the Afghanistan Independent Human Rights Commission, between 60-80 per cent of all marriages in Afghanistan are forced where one or the other partner did not consent to marry

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\(^1\) Marrying a woman to someone as blood money or for the purpose of bringing peace and reconciliation among the families regarding murder, sexual assault or other circumstances following wrong customs and traditions

\(^2\) A tradition of exchanging the girls between two families for marriage. Parents exchange their daughters for marriage.

\(^3\) Marrying a woman to someone as blood money or for the purpose of bringing peace and reconciliation among the families regarding murder, sexual assault or other circumstances following wrong customs and traditions

\(^4\) A tradition of exchanging the girls between two families for marriage. Parents exchange their daughters for marriage.
This leads to social isolation and other forms of mental strain for women living with in laws (49). It has been found that men who have to pay a high bride price may get violent with the wife and other family members, which shows an association between violent behaviour and forced marriages (50,51).

The government in 2017 launched the National Action Plan to Eliminate Early and Child Marriage which seeks to develop and support initiatives to prevent it, and improve the implementation of laws and provision of services to people affected by child marriage (52). UNICEF (2018) launched a study showing that there has been a reduction in child marriage by 10% in the last 5 years but it still remains high (40). There is some positive evidence from a recent study conducted among 12-15-year-old adolescents and their parents that showed approximately 90% of the parents expect their children to complete at least secondary education irrespective of the child’s sex, with more than a third (38%) indicating that marriage should be postponed until at least high school completion. Adolescents on the other hand also stated that child marriage limits their educational opportunities, increases the risk of domestic violence and leads to loss of freedom (53). This shows that the individuals are questioning the practice and countering the existing gender norms and social expectations from the harmful practice.

Nutrition

The National Nutrition Survey (NNS), conducted in 2004, laid the foundation of the first iteration of the National Public Nutrition Policy and Strategy (2003–06). The last and only the second nutrition survey was done in the year 2013, in which the data was collected on adolescent girls for the first time in the country (54). The table below highlights the nutrition difference over a period of 10 years between the first and second nutrition surveys in Afghanistan among women of reproductive age and adolescent girls.

<table>
<thead>
<tr>
<th>Women of Reproductive Age (Non-pregnant)</th>
<th>NNS 2004</th>
<th>NNS 2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Underweight (Chronic energy deficient)</td>
<td>20.9</td>
<td>9.2</td>
</tr>
<tr>
<td>Overweight</td>
<td>12.2</td>
<td>29.0</td>
</tr>
<tr>
<td>Obesity</td>
<td>3.4</td>
<td>8.3</td>
</tr>
<tr>
<td>Anemia</td>
<td>24.7</td>
<td>40.4</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Adolescent Girls</th>
<th>NNS 2004</th>
<th>NNS 2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Underweight (Chronic energy deficient)</td>
<td>Not included</td>
<td>8</td>
</tr>
<tr>
<td>Overweight</td>
<td>Not included</td>
<td>11.6</td>
</tr>
<tr>
<td>Obesity</td>
<td>Not included</td>
<td>2.7</td>
</tr>
<tr>
<td>Anemia</td>
<td>Not included</td>
<td>30.9</td>
</tr>
</tbody>
</table>

Moreover, despite improving from 60.5% in 2004 to 40.9% in 2013, Afghanistan has the highest rates of stunting in the world, indicating towards poor nutrition or mothers before and during pregnancy, inappropriate infant feeding practices and repeated episodes of infections.

The Ministry of Public Health (MoPH) along with development partners is putting continuous efforts and considering nutrition as a fundamental priority, which is evident in MoPH’s Strategic Plan for 2011-2015 where nutrition interventions was listed as the first pillar (55). Additionally, nutrition was also part of the Basic package of health services (BPHS) so as to reach the maximum population. However, limited focus has been attributed to young people until now, noticeable in the document by
UNICEF where Nutrition is mentioned as an excluded topic in the national policies/strategies/ plans for the adolescents (56).

In Public Nutrition Policy Strategy, 2015 a commitment to develop and implement guidance on multi-micronutrient supplementation for non-pregnant adolescent girls and adult women along with UNICEF has been cited. As a result of which, UNICEF with Ministries of Public Health and Education committed to decrease the prevalence of anaemia in adolescent girls through weekly iron and folic acid supplementation in schools and in 2019, over 978,000 million young women were reached, protecting their and future children’s health (57).

Adolescents undergoing rapid growth and development are a nutritionally vulnerable group which is often overlooked. Among women, physiological conditions like pregnancy and lactation increase the probability of nutritional risk (58). With the initiation of menarche, girls are vulnerable to anaemia and associated adverse consequences. Moreover maternal undernutrition (59) and anaemia during pregnancy (60) in adolescent girls will increase their susceptibility to adverse birth outcomes and contributes to the maternal and child mortality and morbidity. The maternal and child mortality in Afghanistan has been reduced to half since 2000, however still among the highest globally. Nutrition is fundamental to people, not only to survive but to thrive. Fulfilling nutritional needs especially for young men and women has a range of positive effects as healthy young people will efficiently generate income, have healthy children and ensure adequate nutrition to their family. As a result, child and maternal mortality and morbidity will be improved and health expenditure will also be minimizing; thereby help in improve countries’ socioeconomic development.

Sexual and Reproductive Health and Rights

The onset of adolescence brings not only physiological and psychological changes to their bodies but also brings new vulnerabilities in a country like Afghanistan in terms of violation of human rights especially for young girls in the arenas of sexuality, marriage and childbearing (52).

Adolescent girls are forced into unwanted sex or marriage, rendering them at risk of unwanted pregnancies, unsafe abortions, sexually transmitted infections (STIs) including HIV, and dangerous childbirths. Both boys and girls are disproportionately affected by HIV as compared to adults. Most of the young people face barriers to sexual and reproductive health information and services.

This section presents the context of young people with respect to SRHR. The data are mostly sourced from the survey as there is sparse evidence from the grey literature; a few studies found in the database search are based on secondary analysis from the surveys published and not much analytical findings could be found.

Sexual debut, attitude and behaviour among Afghan youths

There is lack of literature reporting the age at first sexual intercourse among the Afghans. The data available only makes estimates from the existing health surveys particularly DHS. The DHS and AHS only include ever married men and women and no studies were found (from database and grey literature) that have looked for premarital sex among unmarried young/adolescents, or even the
retrospective analysis of the data in the DHS and in other surveys available in research studies gives no data on the prevalence of premarital sex among Afghan population.

As per the latest survey of Afghan Institute for Strategic Studies on sexual attitudes and behaviours of Afghan youths, most Afghan adolescents did not have information regarding safe and healthy sexual relationship and approximately 60% used sex contents such as movies and photos to satisfy their sexual instinct. The survey further highlighted that such behaviours are linked to increased rape, violence, street harassment, and sometimes avoidance of marriage (61). Afghan women suffer whenever allegations of pre-marital sex and loss of virginity emerge, including death, are extreme, discriminatory and not in the penal code (62). Therefore, data on pre-marital sex remains under reported.

As mentioned above, there is lack of data on sexual debut for unmarried young people, the data on age at first sexual intercourse is available only for those who are married. Afghanistan has the highest adolescent median age at first sex (19.9) among the South and South-East countries (63) which is attributable to early marriage. The proportion of young people having had first sex by age 15 was 12% and by age 18 was 57% respectively. The age of sexual debut is very low among women reflecting inter-spousal age differences (Figure 4). There is an age difference of about 10 years between a woman and man in Afghanistan where men are 10 years older than the women (63).

Pre-marital counselling
Due to high prevalence of child marriage and adverse health conditions of the adolescents and young people in Afghanistan, pre-marital counselling is one step forward to increased awareness of the risks of early marriage and need for healthy lifestyles for adolescents. In collaboration with the Ministry of Public Health, UNFPA held a training of the trainers for Pre-Marriage Counsellor to equip the counsellors with knowledge and information needed for pre-marriage counselling.

Age at marriage
In South and Southeast Asia, men’s marriage during adolescence lags behind that for women. This is especially the case in Afghanistan, where the low percentage of men married during adolescence suggests substantial spousal age differences. Still, 12% of men are married during adolescence in Afghanistan (63). Thirty-five percent of Afghan girls are married before the age of 18 and 9% are married before their 15th birthday(64).

Total fertility rate
The current total fertility rate in Afghanistan among 12-49 years is 5.1 children per woman (13). Data over a decade (from 2005 to 2018) (13,65) has shown a remarkable improvement. The fertility rates declined from 333 live births per 1000 women to 225 per 1000 women among 20-24 years old, and from 146 to 62 among 15-19 years old (Figure ).

![Figure 5 Trends in Fertility rates in 15-19 and 20-24 years old women (data from Afghanistan Mortality Survey (AMS) 2005, 2010, 2018)](image)
Evidence shows that rural women have more children on an average than urban women (5.4 versus 4.4 children per woman) (13). Rural fertility is higher than urban fertility in every age group (AHS 2018). The fertility rates were 65 and 237, 52 and 198 per 1000 women in the corresponding age 15-19 and 20-24 years, in rural and urban areas, respectively (Figure 6). On average, women with no education have two more children than women with more than a secondary education. Therefore, lack of education is also a determining factor for high fertility (13).

Mean ideal number of children in the age group 15-19 years is 4.9 and in 20-24 years is 5.1 (25).

Adolescent pregnancy
Adolescent pregnancy attributable to child marriage (early and forced marriage being common in Afghanistan) contributes to high maternal mortality rates and is a major barrier towards accessing education and employment. Adolescent pregnancy and motherhood (% of women ages 15-19 who have had children or are currently pregnant) in Afghanistan was reported at 12% in 2015 (25).

Twenty-percent of women between the age 20-24 had given birth before the age of 18 years. The median age at first birth among women is 20.1 years. The percentage of female deaths that are pregnancy-related is 64.2 and 69.9 in the corresponding age-groups (Figure 7). In Afghanistan, the perinatal mortality ratio (perinatal deaths per 1,000 live births) is estimated at 48 for mothers below the age of 20 compared to only 38 for mothers aged 20–29 at the time of birth (25). The newborns of adolescent mothers are also more likely to have a low birth weight, which corresponds with a higher rate of long-term health risks (66).

Contraceptives and unsafe abortions
Knowledge and messaging on contraception and family planning
A 5-year trend analysis shows an increasing trend in knowledge about contraceptives among married adolescent girls and young women (Figure 8). Estimates for 2010 are from AMS 2010 (65) and those for 2015 are from AfDHS 2015 (25). More than 90% adolescents and young people across the two age-groups have heard of any or any modern contraceptive methods (Figure 8).
Exposure to family planning messages was low with about 45.5% and 38.6% not exposed to any sources for family planning. Television (24.6% and 29.3%) followed by local community leaders (21.2% and 26.0%), followed by radio (18.4% and 21.9%) and health professionals (17.6% and 22.3%) are among the sources of information about family planning for 15-19 and 20-24 years’ women, respectively. The exposure is more among men where 30.3% and 33.8% not exposed to any sources. Newspaper, Internet and billboard are among the least used sources for FP messaging among both the sexes (AfDHS 2015) (Figure 9).

Need, demand and use of contraception/family planning
The unmet need for both spacing and limiting was higher than the met need in both the age groups (Figure 10) (25). The demand for spacing is 40% among 20-24 years old women as compared to 26.8% among 15-19 years old (Figure 10). Only 6% and 15.3% used any modern method and 7.8% and 17.6% used any method in the age group 15-19 years and 20-24 years, respectively (Figure 11). Of those who used a modern method, pills (2.7% and 6.5%) and condoms (1.4% and 3.6%) are most used methods followed by IUD (0.7% and 1%) and injectables (0.5% and 1.7%) among 15-19 and 20-24 years, respectively (25).

Place of acquiring contraceptives
The data is available for women aged 12-49 years. The private pharmacy is the most sought place for getting the contraceptives, MoPH clinic 27.7%, private clinic/hospital 16.8% and MoPH hospital 12.6% (Figure 12). Community midwives and health workers are the least sought sources of acquiring contraceptives (AHS 2018) (13).

**Figure 9** Exposure to family planning messages from various sources. **Data source AfDHS 2015**

**Figure 10** Need and demand for family planning among young women aged 15-19 and 20-24 years

**Figure 11** Trends in use of contraceptive methods among young women (15-19 and 20-24 years). **Data source AMS 2010 and AfDHS 2015**
Unsafe Abortion
No data are available on unsafe abortions in Afghanistan but unsafe abortion contributes to Afghanistan’s high maternal mortality ratio (6). Abortion is only permitted in Afghanistan in case of medical indications and certifications are required by three medical professionals and the approval of the MoPH. In 2012 the Afghan Government legalized post-abortion care and related guidelines were developed by MoPH which Marie Stopes International described a “monumental achievement for women’s health in Afghanistan” (6).

HIV/AIDS & Sexually Transmitted Infections (STIs)
The recent data from (25) shows a decrease in number of women who have heard about HIV/AIDS (22.3%) with 1% having comprehensive knowledge compared to AMICS data 2010-2011 which showed 30% had heard of HIV and 2% had comprehensive knowledge regarding transmission. Comprehensive knowledge was six times more among 15-24 years old men. Only 1.2% women and no men in the age-group 15-19 years and only 0.2% and 0.8% among 20-24 years old men and women had recently got tested for HIV. Only 14.2% women and 36.3% men in the age 15-24 years know about mother-to-child transmission of HIV while only 8.2% and 21.2% women and men know that the risk of Mother to child transmission (MTCT) can be reduced by mother taking special drugs during pregnancy. Additionally, the testing for HIV is low among young men as compared to the young women.

Self-reported prevalence of sexually transmitted diseases (STIs) is 1.6% and 1.3% among 15-24 years old men and women, respectively. The prevalence among 15-19 years old women is 1.6%) and men did not report any STI (Figure 13).

During and post pregnancy health
Key maternal health services before and post pregnancy show progression over a 5-years period.
Antenatal care:
According to recommendations by the WHO, timely and high-quality ante-natal care (ANC) is key to bringing down the high levels of neo-natal and maternal mortality. Over a period from 2010 (AMS 2010) to 2016/17 (ALCS 2016/17) (7,65) number of women aged < 20 years utilizing ANC services (<20 years from AMS 2010 and 15-19 years in ALCS 2016/17) (6,7,65) has increased from 64% to 72.5%. Seventy-three percent have received ANC from any provider in the age 20-24 years (ALCS 2016/17). Those who received ANC from a skilled provider did not differ much over the years (60.5% from AMS 2010 to 61.6% from AfDHS 2015) (Figure 14). Mean number of ante-natal care (skilled or unskilled) visits by women with a live birth in the five years preceding the survey is 2.5 and 2.1 in the age groups 15-19 and 20-24 years (ALCS 2016/17), respectively, against the recommended eight ANC visits by WHO.

There was no marked increase in the number of women < 20 years who took IFA syrup and intestinal parasite drugs from 2010 (AMS 2010) to 2015 to (AfDHS 2015) (25,65), and the overall prevalence was very low (only 38.6% took IFA syrup and only 3.5% took intestinal parasite drugs). On the contrary, the year 2015 showed a decreasing trend as compared to year 2010, in the number of women who received two or more Tetanus Toxoid (TT) and/or neonatal tetanus injections (Figure 15).

Skilled birth attendance
The number of skilled birth attendants (SBAs) have increased significantly in recent years. Forty percent of births attended by SBAs in 2012 as compared to only 19% in 2006 (6). A secondary analysis of AMS data showed marked improvement in the percentage of women below 20 years who received antenatal care from a skilled provider (from 54 percent of women whose last birth was 36 to 59 months before the survey to 65 percent of women whose last birth was 0 to 11 months before the survey) (6).

Institutional delivery
Forty-eight percent of the women below 20 years have delivered in a health facility (AfDHS 2015). However, there are barriers towards accessing facilities in rural areas. A qualitative study (67) conducted with young women mostly between 20 to 30 years showed and provided more detail concerning barriers to health facilities and institutional delivery. Cost was one of the major barriers found in the study. Other barriers included were distance and social factors that act as inhibitors for women to access skilled providers. Another barrier was asking bribe as ‘sweets’ which means payments to doctors and midwives was mentioned, as a traditional pressure to give gifts for service after happy events. A number of women give birth to children at home because they don’t have money to pay ‘sweets’ to the midwives amounting to AFN 2,000 (about 29 USD) at health facilities.
Postnatal care
Over a period of five years (from 2010 to 2015), there has been progress in the number of adolescent girls and young women (15-24 years) who received postnatal check-up any time before 42 days (Figure 16).

Thirty-seven percent (37%) of women had received a postnatal check-up in the first 2 days after birth in 2015 (AfDHS 2015) as compared to only 25.6% in 2010 (AMS 2010).

A progress in improved maternal health care and services, has led to decreased maternal mortality, neonatal mortality and under-five mortality among Afghan women.

Young vulnerable Populations and their health
Migrants and Internally displaced people
According to UNHCR there are almost 2.5 million registered refugees from Afghanistan which is the largest protracted refugee population in Asia and second largest in the world (68). Having experienced over four decades of conflict Afghanistan has an estimated 1.2 million internally displaced persons (IDPs), a majority of which are concentrated in urban centres (6). IDPs have limited resources and face challenges accessing health services, leading to a disproportionate burden of morbidity and mortality (69).

Injecting drug users
Afghanistan has a low HIV prevalence among the general and key population groups except for injecting drug users (IDUs). According to the IBBS 2012, the HIV prevalence rate among IDUs in five Afghan cities was 4.4 percent, with wide variations between cities. Nearly 70% of the participants were between 18-30 years in all provinces except Herat. There is evidence from a study conducted in 3 Afghan cities that showed IDU’s with high risk behaviours 30.2% reported needle sharing in the last 6 months, 23.1% reported sex with another male, and 50.4% reported paying females for sex (70). Behaviours varied significantly by site. Although access to needle and syringe exchange programs and other harm reduction services has been increasing in Kabul (71), scale-up of services should continue, aiming to provide a comprehensive package of harm reduction services, including opioid substitution therapy to cities were injecting drug use appears to have the highest impact (72).

Female sex workers
Globally, female sex workers (FSWs) are 13.5 times more likely to be living with HIV than other women (73). According to UNFPA 2014 report FSWs in Afghanistan play a predominant role in the HIV transmission dynamic, as they are linked to different sub-populations such as military personnel, civil servants, police, and truck drivers where sex work in commonly reported (United Nations Population Fund (6). The report further stated since sex work is illegal in the country, accurate information on the prevalence, age-profile and characteristics of sex workers are not available. The IBBS 2012 survey showed that the HIV prevalence among FSWs is 0.3% (74). A UNFPA report stated that in a FSWs (n=1,032) survey, the largest proportion of sex workers belonged to the 18–24 year age group (Kabul 44.4 percent, Herat 28.7 percent and Mazar-i-Sharif 36.9 percent). But adequate knowledge on HIV prevention was low in all the states. IBBS 2012 survey among 18-24 year olds stated that 57.8% could not read or write, 59.8% reported 2-5 clients in the last one month, 41.7% had heard of STIs, 69.5%
had heard of condoms and only 52.3% of them had used a condom while they had sex the last time (74).

**Men having sex with men**

Little is known about the extent of MSM behaviour or the magnitude of the MSM population as it related to the tradition of sexual relationships of adult men with younger men and boys, including sexual exploitation of younger boys (75). MSMs are highly stigmatised and discriminated in Afghanistan as under the Islamic law homosexuality is prohibited. However, the HIV prevalence among MSM is 0.4% (74). A mapping assessment revealed that many MSMs have female partners/spouses, young males partners and reliance on drugs (76). In addition, many MSMs engage in commercial sex work and have multiple sexual partners which is largely unprotected. There is evidence on the inadequate knowledge on SRH among MSMs from a survey conducted by IBBS in 2012 in Kabul which showed that only 51.6% had heard of HIV, 73.4% had heard of condom and 65% stated that they had repetitive anal sex with men in the last 12 months and almost 50% had bought sex from women (74).

**Gaps identified through the review:**

1. There is no specific research data available on young people’s sexual and reproductive health and rights. Moreover, secondary analyses of the survey data available in the literature lacks focus on analysing age-specific sexual and reproductive health indicators.
2. There were no studies found in this review that focused on premarital sex among young people.
3. There is paucity of data on sexual debut and age at first sexual intercourse among unmarried adolescents and the data available in the national surveys is only for the ever married population.
4. There is lack of data on unsafe abortions which is a significant contributor to the maternal mortality in the country.
5. There is lack of accurate data on their needs, circumstances and prevalence of MSMs, FSWs, IDUs, migrants and internally displaced people.
6. There is also no recent empirical evidence on the HIV/STI prevalence in the vulnerable key populations or the general population.
7. Since the national strategies have recently acknowledged adolescents and youth as distinct groups, there is lack of country level data on the common mental health disorders and suicide related indicators.
8. Nutrition was a part of the Basic package of health services (BPHS) but limited focus has been given to young people till now.

**Limitation of the desk Review:**

This review collated findings from databases and grey literature along with some secondary data reports available as National level surveys. The research articles were extracted only from three databases and the timeline is restricted for last 10 years due to the limited time allocated towards the said activity. The unpublished reports were not reviewed because of inaccessibility, nonetheless the reports can be reviewed when shared with MAMTA as we proceed further with the current assignment.
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Annexures

Figure 17: Analytical Framework for Desk Review

- **TA MECHANISM**
  - Needs Assessment (MAMTA-HIMC)
    - Desk Review
    - Development of Search Strategy
    - Literature Review
      - Scientific Databases: PubMed, Medline, ProQuest
      - Grey Literature: Partner’s Websites, Relevant department websites (Health, Education, Women), Unpublished Reports (Provide by CARE, if available), Local NGOs’ Website
    - Secondary Data Analysis: DIS, NNS, HMIS (MoPH, if access provided)
  - Landscape Analysis (CARE)
    - Review of Programmatic documents
    - KIs

- **PRIORITIZATION**
  - Young People/Couple and Adolescents including Vulnerable group (Refugees, Displacement population)
  - Indicators: DALY, QUALY, Prevalence’s etc
  - SRHR
    - Mental Health
    - Nutrition
    - Education
    - Violence
    - Maternal Health
  - Determinants: Risk & Protective Factors, Social & Gender Norms, Socio-cultural factors
  - Gap Analysis