Women's Participation in Domestic Violence Health Policy Development:

Afghanistan Component

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Research Report

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WDVHP
Women's Domestic Violence Health Project

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A CIHR Global Health Research Initiative planning grant supported the development of an existing partnership between the University of Calgary and Edith Cowan University, Perth, Australia to include partners in Afghanistan, Bangladesh and Thailand and planning for a shared international research program advancing knowledge of participation in and gender analysis of health policies with the focus of addressing domestic violence. A five-day face-to-face meeting brought the team members together to develop the program of research, and a pilot project was selected as the most appropriate beginning to assess our capacity to conduct research in five countries, to communicate with stakeholders, and identify future collaborators. The project, supported by a Global Health Research Initiative pilot project grant, was designed to investigate the participation of women in the development and implementation of effective domestic violence health policies. Research was conducted by local teams in each of the five countries, and resulted in individual country reports, as well as a comparative report, which are all available on the website.

Women's Participation in Domestic Violence Health Policy Development: Afghanistan Component. Jennifer Hatfield, Wilfreda E. Thurston & Sadiqa Basiri. June 2008.

Women's Participation in Domestic Violence Health Policy Development: Australian Component. Colleen Fisher, Lynne Hunt & Rhonda Adamsam. April 2005.

Challenges and Gaps in Addressing Domestic Violence in Health Policy of Bangladesh. Kaosar Afsana, Sabina Faiz Rashid & Wilfreda E. Thurston. October 2005.

Women's Participation in Domestic Violence Health Policy Development: The Southern Alberta Aboriginal Community [Canada]. Wilfreda E. Thurston, Jennifer Hatfield, Leslie Tutty, Cora Voyageur & Amanda Eisener. December 2006

Characteristics of Women's Domestic Violence Health Policy Communities in Thailand. Pimpawan Boonmongkon, Orasa Kovindha, Wilfreda E. Thurston & Niporn Sanhajariya. June 2005.

Comparing Descriptions of Domestic Violence Health Policy Communities in Five Countries: The Women and Domestic Violence Health Project (WDVHP). Wilfreda E. Thurston & Jennifer Hatfield, with the WDVHP Team Members. January 2007.

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INTRODUCTION

This report comprises the Afghanistan component of an international project examining women's participation in family and domestic violence health policy and policy development. Carried out across five different countries – Canada, Australia, Bangladesh, Thailand, and Afghanistan – the goal of the project was to describe the characteristics of the domestic violence health policy community in each country. There is a separate report for each country involved in the project, as well as a report on the comparative analysis of the five studies.

This report begins with a rationale for the project and an introduction to the unique situation facing women in Afghanistan. A brief history of the recent conflict and current political situation follows. A description of the Afghan health sector and a summary of government and non-governmental organizations' attempts to address violence against women and domestic violence are provided. The research methods of the study are described. Following a report of the results, there is a discussion of the analysis and concluding statements.

RATIONALE

Domestic violence is a common form of gender-based violence. The Pan American Health Organization (PAHO) stated: "Gender-based violence is one of the most widespread human rights abuses and public health problems in the world today, affecting as many as one out of every three women" (Velzeboer, Ellsberg, Arcas, & Garcia-Moreno, 2003, p. xi). The World Health Organization (WHO) has also recognized that gender-based violence is a major public health problem and identifies it as a human rights problem. According to the WHO: "Violence against women has profound implications for health but is often ignored" (WHO, 2006). Domestic violence reduces health and well-being and increases health care utilization. There are many reasons why domestic violence should be considered a serious problem for public health practitioners, the health sector in general, and the health policy community, however, the public health and health sectors have not had a large role to play in domestic violence prevention.

Afghanistan has suffered more than 35 years of war and the resulting disintegration of health, education, judicial, political, and civil institutions (Cardozo et al., 2004). Violence against women and domestic violence have only recently emerged as public policy issues. Indeed the form that violence takes and its prevalence is a stated concern of the Karzai government which has sought to place women's rights at the forefront of its democratic reforms. Although no reliable statistics exist regarding the incidence of violence against women in Afghanistan, international human rights organizations, such as Amnesty International and the United Nations (UN), and national human rights organizations, such as the Afghan Independent Human Rights Commission, all state that the situation for women is desperate.

Yakin Ertürk, UN Special Rapporteur on Violence Against Women, reported that women in Afghanistan face very high rates of violence as a result of war, poverty, and the destruction or disintegration of key institutions. She described rape, trafficking, and physical abuse as common place (Ertürk, 2006). Amnesty International reported a clear pattern of widespread underage marriage of girls, particularly in rural areas. Girls as young as eight are married to older men, and it appears relatively rare for girls to remain unmarried by the age of 16. Forced marriages are also frequent as a means of dispute resolution by informal justice mechanisms. Women are

exposed to many potential abuses: denial of the right to physical integrity; infringement of women's right to education; and death in childbirth due to the lack of health facilities and due to the bride's young age. Amnesty International also reported that women who are detained for offences, such as appearing in public without a male relative, are often subjected to physical examinations of their virginity carried out by male forensic specialists. Female prisoners have reported sexual abuse by staff (Amnesty International, 2003). According to the Revolutionary Association of the Women of Afghanistan, an Afghan women's rights organization, new schools opened for girls are frequently burned to the ground. They also report women in rural areas, where 85% of the population lives, fear roving militia groups and lawlessness in these regions makes "their lives worse than during the Taliban era." The practice of self emollition (setting oneself on fire as a method of suicide) is an all-too-frequent means of escape (RAWA, 2005).

Although the situation in Afghanistan is unique and research has yet to be conducted on the impact of violence on the health of women in this country, the situation worldwide is clear. Health status is reduced by violence against women and domestic violence in all counties where it has been studied. Violence against women and domestic violence increases health care utilization. In addition to physical and psychological injury, evidence suggests that domestic violence results in increased rates of illnesses (Jaffe, Wolfe, Wilson, & Zak, 1986; Larsson & Andersson, 1988), sexual ill health (Campbell, 2002; Campbell & Soeken, 1999; Radomsky, 1995; Campbell, Moracco, & Saltzman, 2000; Jewkes, 2000; Davis, 2002; Leung, Leung, Chan, & Ho, 2002; McFarlane, Parker, & Soeken, 1996; Wingood, DiClemente, & Raj, 2000), and chronic health conditions, stress, and substance use (Thurston, Patten, & Lagendyk, 2006). Mental health problems are another common result of violence (Bergman & Brismar, 1991; Hathaway et al., 2000; Plichta, 1992; Stewart & Cecutti, 1993; Bauer, Rodriguez, & Perez-Stable, 2000). The effects of psychological abuse also have consequences for the long-term health of abused women (Radomsky, 1995; Kernic, Wolf, & Holt, 2000; Wagner & Mongan, 1998). Violence is associated with serious consequences for women's reproductive health, yet our understanding of the relationships between the two experiences remains limited (Campbell et al., 2000). Violence and the fear of violence may intimidate women and prevent them from trying to negotiate safer sex, discussing fidelity with partners, or leaving risky relationships. The problem is exacerbated in conflict, post-conflict, and refugee situations where women and girls are subject to high rates of sexual assault and increased vulnerability to prostitution and trafficking (Waldorf, 2001). Ertürk (2006) argued that in areas of conflict such as Afghanistan differentiating domestic violence from other forms of widespread violence against women may be impractical.

RECENT HISTORICAL CONTEXT

Afghanistan was invaded and occupied by the Soviet forces from 1979-1989. After the Soviets withdrew from the country, there was factional fighting among the Afghan resistance forces (Mujahideens) vying for power. In 1996, the Taliban, one of the factions, won and came to power. The Taliban, a religious fundamentalist group, promulgated numerous edicts or policies to regulate life in Afghanistan in accordance to their strict interpretation of the Islamic law (Sharia) and what they see as true Islamic principles. Although the Taliban did not control the whole country, the restrictive and oppressive practices against women were perpetuated by war lords across Afghanistan.

During this period, women and girls faced severe restrictions on their freedom of movement and access to health care, education, and employment. Rasekh, Bauer, Manos, and Iacopino (1998) described life under the Taliban: women were forbidden to work outside the home (except for those working in the health care professions), were confined to their homes unless accompanied by a male relative, and were forced to wear a burqa (shroud), with only a mesh opening to see and breathe through.

In November 2001, the Taliban was overthrown by a US and coalition-led military campaign. The Afghan Transitional Administration was established under the Bonn Agreement at the end of 2001, and it governed the country until 2004 when a fully representative government was elected. However, there are still warlords and religious conservatives who rule in the Afghan society, and this remains a reality for the majority of provinces beyond the capital of Kabul. War and violence continue to be a feature of every day life for Afghans in all but a few provinces.

THE HEALTH SECTOR: THE AFGHANISTAN CONTEXT

After the fall of the Taliban regime, the health sector was unable to function. Decades of war had damaged or destroyed the fragile health care infrastructure (Ahmad, 2002). Health personnel had been displaced or killed, and there was a critical shortage of health care workers. Mental health services had disappeared. In 2002, it was estimated that six million Afghans had no access to basic health care, and medicine, vaccines, and other medical supplies were not available in rural areas (Brundtland, 2002).

The federal government is now engaged in a process of rebuilding Afghanistan's public health system from the ground up, in partnership with many UN and international aid organizations, and international and national non-governmental organizations. The focus is on delivering a basic health services package to the country's citizens. The task is monumental. Life expectancy at birth for men is 44.0 years and for women is 44.4 years (CIA, 2008). Maternal mortality rates are one of the highest in the world, estimated in one study to be 160 per 10000 live births (Bartlett et al., 2002), while another report puts the rate at 155 per 1000 live births (CIA, 2008).

A regionalized health care system is being developed. Government reports suggest that up to 70% of the population now has access to some form of basic health care; however, conflicting reports suggest this is an overestimation. The health care system is not publicly funded and operates on a fee for service basis, although free care is being offered in some non-governmental organization programs and government clinics. One of the greatest challenges facing the new health system is the problem of communication and coordination between the hundreds of non-governmental and international organizations and the Afghan government. The fragmentation of health services and a lack of documentation generally contribute to difficulties in health surveillance and monitoring of the health system. In this context, it is especially difficult to obtain agreement on the reporting of violence against women and domestic violence, even if health providers agree this is an important health issue.

Although there has been a slight improvement in women's access to health care, it remains severely limited, especially in rural areas. Reilley, Frank, Prochnow, Puertas, and van der Meer (2004) reported, for instance, that women's access to medical treatment continues to be impacted

by cultural prohibitions on women's movement beyond the home and the requirement for women to be accompanied by a male relative.

ADDRESSING VIOLENCE AGAINST WOMEN AND DOMESTIC VIOLENCE IN AFGHANISTAN

Violence Against Women and Domestic Violence: The Justice Sector

Afghan society is patriarchal. Many women, particularly in rural areas, follow traditional practices of behaviour, including purdah which constitutes a wide range of prescriptive practices for women such as not leaving the home unless accompanied by a male relative. International human rights organizations argue that these restrictions, combined with increased war-related tension in the household, engender domestic violence (Van de Put, 2002). Ertürk (2003) argued that Afghan women have been especially vulnerable during times of recent conflict and the resulting refugee crisis. Moreover, violence against women in Afghanistan is perpetuated because there is impunity on a vast scale for such violence (Amnesty International, 2003). Since the perpetrators of violence against women are not punished, mainly because of the inefficient criminal justice system, perpetrators continue to abuse women without fear of judicial intervention.

In Afghanistan, few cases of abuse and violence are reported to the criminal justice system, and almost none of the cases that were have been subject to investigation or prosecution (Amnesty International, 2003). Thus, unlike other countries such as Canada, there are no police or justice system statistics documenting the extent and nature of these crimes against women. Ertürk (2003) stated that authorities do not acknowledge or adequately respond to violence against women by their spouses or other family members within the home. Even in serious cases, the police and the courts do not treat domestic violence as a criminal offence. Ertürk (2003) reported that the criminal justice system does not protect women's rights and does not protect women against violence. Advocates charge that the judges classify domestic violence as a family issue and therefore decide that it must be dealt with in the family, not the courts (UNIFEM, 2005). In the Green Left Weekly (2004), a former UN officer in Kabul stated: "Those women who overcome the powerful barriers and seek redress are unlikely to have their complaints considered, or their rights defended." In the case of rape, the woman will often be accused of dishonouring her family, charged with adultery, and imprisoned.

Virtually no services, such as legal aid clinics and shelters, exist to protect women from these or other human rights abuses. The shelters for women fleeing violence that have developed rely largely on non-governmental support and require armed security at their gates. Some are dependent on foreign non-governmental funding. These services do not have the latitude to specialize their services as have those in Canada or Australia or the United States.

Under the Afghan Transitional Administration, a process of justice and legislative reform was begun. There are many changes needed to strengthen the ability of women to seek justice. Amnesty International (2003), for instance, recommended that a process to establish safe and just hearings where women could make complaints be strengthened. They also argued that measures be created to ensure that forced and underage marriages no longer take place and that a system be established for consistent registration of marriage and divorce, in part, so that women can

prove their position. They called for measures to be taken so that deaths of women and girls that may have been caused by violence in the family are investigated and the perpetrators charged. Ertürk (2003) stated: "The Afghan Transitional Administration should abolish laws that discriminate against women and girls and lead to their imprisonment and cruel inhuman and degrading punishment" (p. 11).

One of the challenges facing those who are working to change the situation for women in Afghanistan is the lack of solid statistics and the dependency on anecdotal evidence to evaluate the impact of campaigns to improve the police response to violence against women (Ertürk, 2003). As a remedy to the inefficacy of the criminal justice system, Ertürk suggested the empowerment of vulnerable women through free legal advice and counselling, the training of judicial personnel, and the empowerment of the Afghan Women Judges Association, which was founded in March 2002. Training for women lawyers and judges is now underway.

Initiatives to Address Violence Against Women and Domestic Violence

At the national policy level, Afghanistan is a signatory to the UN's *Convention on the Elimination of All Forms of Discrimination against Women* (CEDAW), and has initiated initiatives to improve women's human rights. The government has publicly welcomed international non-governmental organizations with mandates to improve the status of women, and President Kharzi has hailed the work of women's rights advocates. In October 2005, the Supreme Court, Attorney General, and university scholars were brought together to draft a new law against violence against women (UNIFEM, 2005). In addition, law enforcement agencies in Kabul are being informed of their responsibilities to investigate violence against women and killings of women and girls that may have been caused by violence in the family (UNIFEM, 2005).

The creation of the Ministry of Women's Affairs is another attempt to deal with discriminatory attitudes and social practices. The Unit of Mental Health, which is part of the Department of Health within the Ministry of Women's Affairs, has been given the mandate to coordinate with hospitals, private clinics, and other concerned institutions to develop and deliver services that could cater to women who are victims of gender-based violence. The Unit's website states that their mandate is to facilitate advocacy and education on mental health issues and to respond to issues of violence against women (Ministry of Women's Affairs, 2006).

In February 2005, the organization Voice of Women implemented a three-day workshop on violence against women and legal rights training, which was supervised by a trainer from the Afghan Women's Network. Twenty-five participants from government and non-governmental organizations attended this workshop to improve their knowledge. The training topics included: definition of violence, types of violence, men's and women's rights according to Islam, and other culturally sensitive topics.

The Afghan Institute of Learning (2006) reported that besides policies and initiatives to improve women's human rights, initiatives to directly address the issue of violence against women have also started. Classes, workshops, campaigns, training programs, films, and communication materials are now being provided by government and non-governmental organizations. Through these programs, it is hoped that women will increase their knowledge and develop skills in

communication to affect positive change within their families and society to prevent violence against themselves and other women.

Afghan women who experience violence have historically had very few options for their safety. Kabul has a few government-run safe houses for battered women; some women use Kabul's hospital for psychiatric patients as a safe house. Specific programs, such as Medica Mondiale's efforts to provide psychological counselling for women who have suffered violence, are constantly under threat from a lack of funding and for security concerns.

Medica Mondiale's (2006) continuing leadership and involvement is evidenced in its Annual Report. The report called for health centres in the provinces and better equipment and modernization in the existing centres. It further stated that access to hospitals and doctors must be improved, particularly in rural areas. Within the report, research on the issue of self-emollition was documented, and the report called for the creation of new policies recommending that all medical staff in all professional groups be trained to deal with burn victims, and for forensic investigations of cases of suicide and self-emollition.

Research activities are severely limited due to the security concerns both in and beyond Kabul. Within this context, the focus of many health-related organizations continues to be on the provision of the most basic of health services to the population, that is, treatment of injuries and illnesses and maternity care.

RESEARCH METHODOLOGY

The conceptual framework behind this study involved public policy development processes. Public policy making represents a process that involves policy makers operating within the governmental arena, as well as a diverse set of constituencies that functions to pressure the government and to influence the public policy making process (Rist, 1994). Howlett and Ramesh (1995) distinguish the actors in the policy cycle. The actors in a policy subsystem have at least some knowledge of the topic (e.g., domestic violence) and form a Policy Community. Some members of the Policy Community interact on a regular basis and these form Policy Networks. Advocacy Coalitions form yet another subset of the Policy Community. Members of coalitions share a basic set of beliefs (policy goals plus causal and other perceptions) and seek to influence governmental institutions in order to achieve their policy goals (Howlett & Ramesh, 1995). Thus, the focus of this first study was the Domestic Violence Health Policy Community in Afghanistan.

Initiation of the Study

In Afghanistan, Zorah Rasekh, who had recently been appointed Director, Division of Women's International Affairs and Human Rights, Ministry of Foreign Affairs, in the Afghan Interim Government, agreed to be a member of the research team. In addition to her new government position, she was the President of a non-governmental organization for Afghan women. She had documented the health needs of women in Afghanistan and in refugee camps on the northern border of Pakistan, and she had briefed numerous international bodies (such as the UN Development Fund) regarding her findings. Ms. Rasekh attended a team meeting in Canada where a program of research was developed leading to this pilot project. Additional support in

networking was provided by W4WAfghanistan (http://www.w4wafghan.ca/), represented by Janice Eisenhauer. W4W supports several Afghan health non-governmental organizations.

In May 2004, assisted by Ms. Rasekh, Drs. Wilfreda Thurston and Jennifer Hatfield traveled to Afghanistan to initiate work on the WDVHP project in that country. This trip had several objectives:

- to meet with as many organizations and government departments interested in the issue of domestic violence as possible;
- to gain an understanding of the unique regional challenges facing women in Afghanistan;
- to obtain access to documents and reports of local, national, and international organizations working in the area;
- to offer training in research methodology as a capacity building exercise; and
- to identify, select, and train an Afghan research coordinator to recruit a team of interviewers to assist in data collection.

Ms. Rasekh provided invaluable support with introductions to high level officials, shelter workers, and organizations concerned with violence against women and domestic violence and in her assistance with identification of participants for the research methodology training. Subsequent to the training in research methodology, Ms. Sadiqa Basiri was employed as the research project coordinator in Kabul. She brought extensive experience with women's non-governmental organizations and knowledge of women's rights and violence against women in Afghanistan.

A case study design (Cresswell, 1998) relying primarily on qualitative data (Creswell, 1998; Guba & Lincoln, 1989; Holstein & Gubrium, 1994; McDonnell, Jones, & Read, 2000; Paton, 1993; Patton, 1997; Stake, 1994; Yin, 1994; Yin, 1997) was used for this project. Data were collected from review of key documents, observation, and interviews.

Selection of Key Documents

Source documents pertaining to the issue of violence against women and domestic violence in Afghanistan constituted one set of data. These included reports generated by the WHO; meeting minutes of the UNIFEM group that coordinated research and program development efforts on violence against women and domestic violence in Kabul and Afghanistan as a whole; documents and meeting minutes from Afghan Ministry of Women's Affairs and The Afghan Independent Human Rights Commission; newsletters and reports from agencies, such as, but not limited to Human Rights Watch and W4WAfghanistan; and reports issued by the UN and Amnesty International These documents were selected based on the following criteria:

- They were recommended by reputable researchers or program developers in Afghanistan.
- They were recommended by reliable informants in Afghanistan, and were based upon the most reliable data available at the time and were gathered in a systematic way by recognized authorities who spent time in Afghanistan.
- They provided information regarding the methods used to access and gather information.

The informal communications of Drs. Thurston and Hatfield, during their meetings in Kabul, with key informants concerned with the issue of violence against women and domestic violence provided information about potential source documents and additional information on the issues from the perspective of these representatives.

Sampling and Data Collection Using Interviews

Selection of Participants

The sampling strategy was purposive; critical cases were identified and then snowball sampling techniques used to broaden the sample based on the source groups (Patton, 1987). Initially, key contacts in non-governmental organizations assisted in the identification of individuals who could speak to the topic of violence against women and domestic violence in Afghanistan. A letter describing the research goals was translated into Dari (language spoken in Afghanistan). Contacts were made by telephone due to the lack of any postal service in Kabul. People from a variety of sectors were contacted for interviews, including: members of the Ministries of Education, Justice, and Health; members of the Ministry of Women's Affairs; Afghan national non-governmental organizations and human rights organizations; international aid agencies including UNIFEM; international non-governmental organizations; women's organizations; and shelter staff. Participants who agreed to be interviewed were asked in their interviews if they could identify other potential participants. Transportation limitations, security issues, and limited financial resources meant that it was necessary to limit the number of interviews. Twenty-nine interviews were completed in Kabul, and provided a good sample of individuals concerned with violence against women and domestic violence within the city, and were considered to represent the Domestic Violence Health Policy Community in Afghanistan.

Interviews

Interviews with participants were conducted between January and March 2005. Each interview was approximately one-hour long and was completed in person by either the Afghan research project coordinator or one of four other trained interviewers. All interviewers used similar techniques and an identical interview protocol, a semi-structured interview guide. All interviews were audio-recorded and then transcribed in the original language (Dari or Pashto) of the interview. Transcripts were reviewed by the interviewer, following which the text was translated into English for the purpose of analysis. The English transcripts were brought to Canada by the Afghan research project coordinator, and analysis was started in October 2005.

Analysis and Writing

A stated intent of the research was to identify the members of the policy community and assess the degree to which the health sector was involved in prevention or intervention in violence against women and domestic violence. Data were analyzed and triangulated to develop a thick and detailed description of the existing Afghan Domestic Violence Health Policy Community, its network, and its relationships with other groups. Key to the analysis was the examination of the participants' definitions of violence against women and domestic violence. Interview data were examined in the context of the published literature and other sources of data, including the review of selected documents and observations from the trip of Drs. Thurston and Hatfield and from key informants from W4WAfghanistan and Medicial Mondiale.

An analytic template (Crabtree & Miller, 1992) was developed by the Canadian research team and the Afghan research project coordinator. Thematic analysis using memoing, coding (Strauss & Corbin, 1990), immersion, and crystallization (Borkan, 1999; Crabtree & Miller, 1999a) was conducted, and the analytic template was modified as needed to accommodate the data collected for this study. Connecting and legitimating (Crabtree & Miller, 1999b) through reviewing the texts and identified themes were done in conjunction with revisiting the relevant literature, document review, and observation notes. The identified themes were legitimated through a process of reviewing the texts and in consultations between the Afghan research project coordinator and the Canadian analysis team, in face-to-face meetings in October 2005 as well as email communications through to January 2006. In this way, different disciplinary and experience perspectives were used in the interpretation.

Several techniques common to qualitative research were used to ensure that standards of rigor were met for external validity (Patton, 1987; Meadows & Morse, 2001) and within-project validity (Meadows et al., 2001; Lincoln & Guba, 1985b; Kuzel & Like, 1991; Denzin, 1989). Situating the study in the literature, bracketing, and methodological cohesion (Meadows et al., 2001; Patton, 1987) were used as strategies to ensure external validity. Within-project validation was addressed through using multiple research team members to develop codes and interpret the data, searching for disconfirming evidence, and thick description (Meadows et al., 2001; Lincoln & Guba, 1985a; Kuzel et al., 1991; Denzin, 1989).

During the analysis, it was recognised that there had been significant challenges translating the interview protocol from English to both Dari and Pashto. Some of the English words did not have equivalent words in the local vernacular. The research team in Afghanistan did their best to substitute and explain the meaning of questions being asked. The problem of interpretation emerged again when the interview transcripts were translated into English. The translations were not always grammatically correct, but the decision was made to present quotations verbatim in an attempt to represent the responses of the participants in as realistic a way as possible.

Research Ethics

This project was submitted to the University of Calgary Conjoint Health Research Ethics Board for review. A letter of informed consent clarified the purpose of the research, the extent of involvement, potential for harm, rights, privacy, and confidentiality, and all interview participants either read and signed the consent form, or provided verbal consent to confirm their understanding of the contents of the consent form as explained to them.

Many of the participants were concerned about speaking publicly on sensitive issues. It was acknowledged that in Afghanistan speaking out about violence against women and domestic violence is a high risk activity, as these conversations often centre on cultural and religious practices, human rights, and women's lack of access to health and justice. Therefore, participants were assured that no individual or agency would be identified by name in any report.

The ethical and security concerns regarding identification of groups and individuals impacted the presentation of the data. Identifiers for quotes are intentionally vague, indicating only the type of organization to whom the participant belongs. Generic terms are used as labels for the quotation sources: NGO, National NGO (referring to Afghanistan), International NGO, Government (with

sector), and Intergovernmental (e.g., UN). Although this is intentional, it has the negative effect of limiting the ability to report on the direct relationships between specific agencies.

RESULTS

Orienting Discussions of Violence Against Women and Domestic Violence to the Taliban Era and Repression of Women's Rights

The interviews revealed that prior to and during the Taliban regime, violence against women was not discussed openly within Afghan society. All participants spoke of the Taliban era as a defining period in Afghan history, and most oriented their discussion of violence against women and domestic violence in relation to this period. The interviews cited the violation of women's human rights as one rational for the international involvement in the war against the Taliban. This was confirmed in documents and reports from organizations such as Amnesty International. The framing of violence against women and domestic violence as a human rights issue was not surprising because the interviews took place only two years after the coalition overthrow of the Taliban. However, there was also evidence in the interviews that violence against women and domestic violence were common before the Taliban period. Therefore, although the Taliban era is seen as particularly difficult for women due to the repression of their rights to education and freedom of movement, according to the participants the denial of women's rights preceded the Taliban era and continues today.

The narratives provided by the participants suggested that the profile given to women's rights and women's participation in government is new in Afghanistan. The orientation to the Taliban period serves as a dividing line between the past and the present and marks the time in Afghanistan's history when violence against women and domestic violence was characterized as a women's rights issue.

The participants frequently noted that the rights of women and recent constitutional changes in Afghanistan have provided further impetus for dialogue about violence against women. Every participant made reference to these historical forces as a way of contextualizing their responses. This distinction between the "past" Taliban era and the current "new era" of democracy was a defining feature in the interviews.

The linking of violence against women and domestic violence with women's human rights led one participant to suggest that a lack of women's rights was both the cause and the effect of violence. That is, women who lack rights are vulnerable to violence and those who experience violence are prevented from realising their rights. Participants also pointed to "cultural traditions" to explain the prevalence of violence in Afghan society before, during, and after the Taliban. In the excerpt below a participant, who works in one of Afghanistan's many organizations focussed on improving human rights, raised the issue of rights. This participant suggested that the violence predated the Taliban and was enforced by cultural beliefs.

> Well, we are a Muslim country where we are given rights to respect human. Besides that there is international human rights law and many other conventions signed by Afghan government that should compel us to avoid gender-based violence. But unfortunately we have ignored almost all of them so far. Since ages

> we are experiencing that women have not been given any status. They are sold and used as money. Even today we notice 90% mental and physical violence that is enforced by our cultural, social, and political beliefs. As a Muslim I believe that men and women have been given equal rights by Almighty Allah thus I personally stand against any kind of violence…. To see the nature a baby boy or girl is reared by a woman who we call a mother. Mother is the one who looks after boys and girls. Then why as grown men we forget about this greatest status of women, why we diminish their rights? (NGO)

One participant put it most succinctly:

> Any action which is happening against women's will and ability is called violence…. I would like to say that depriving women of their rights in general is violence against women. (Government)

Describing Violence Against Women and Domestic Violence in Afghanistan

There was unanimous consensus among participants that inequality between men and women is a profound social problem in Afghanistan that contributes to violence against women. A lack of public condemnation of inequalities, poor economic situations, and forced childhood marriages were viewed as contributing to these inequalities. "BAD", the practice of selling or giving young girls in marriage or as a means to resolve disputes, was repeatedly cited by participants as a practice typifying the traditional beliefs about women's role status within society. This common practice was considered an act of violence. Girls as young as eight years old are given in marriage to often older men, sent from their family to the husband's home, and may be forced into sexual relations and early child bearing. The young girls have no say in this process and are frequently denied education.

> The recent findings of our researches show that in many places the worst type of violence that happens at large is called *BAD* that means solving a dispute by marrying a daughter into the rival family…. (NGO)

Participants named many examples of violence against women and domestic violence stating that it was a constant feature of a woman's experience throughout her life. That violence against women is embedded in a general devaluing of girls and women, if not misogyny or hatred of the female, is revealed in the following:

> Gender-based violence has mentally affected women. Unfortunately violence is associated with women since their childhood; it means it starts by disgracing words of some parents and it continues at the husband's house. To insult women is a serious form of violence against women. (NGO)

The pervasiveness of the problem was articulated by an Afghan member of a human rights organization who articulated a continuum of violence including a lack of access to decision-making. The important feature of this participant's contribution was the reference to domestic violence described as part of family dynamics.

> Not only in Kabul, but all across the country there are different kinds of violence that women are coming across with. For example, in rural areas, women inside their houses and out of their houses are always subjected to violence. This is because most of the innocent girls and women are married to warlords and local commanders who behave with them as worse as possible. Most of these women are beaten by their in-laws, even the sister-in-laws who live with women in one house. Most of the women are beaten by their brother-in-laws. Most of these women are completely excluded from decision-making and how can a woman make decision…. Currently we are the only few organizations that mostly work on such issues. (NGO)

The interviews revealed a set of definitions and a scope of violence that covers the lifespan of women. Violence largely takes place in private settings, and existed prior to the recent wars but has been exacerbated by them. Women were characterized as a group who lived with violence. The continuum included physical, mental, and sexual violence. Participants stated that a lack of access to education, decision-making, and political participation also constituted violence.

Suicide and Attempted Suicide

A common theme and a deep concern for many participants was the increased reporting of suicide and attempted suicide among women. Suicide was viewed as a victim response to a wide range of violence. Self-emollition, where women intentionally set themselves on fire, was frequently cited. It was represented as a response to the often desperate situation in which women find themselves. In the following excerpt, a participant responded to the question regarding his understanding of the terms gender-based violence and violence against women:

> In my point of view violence is the cause of backwardness of Afghan society and existence of unacceptable traditions and culture. Therefore we count women in the second category and do not give them the position where they should be. In many cases the violence or discrimination against women leads to committing suicide and worry-anguish. We have experienced many of such cases in Herat province. More than 300 women went through self-emollition due the customary law out there. In short, I would say that accusing, insulting, beating, injuring, killing, raping, and worry-anguish are all violence against women. (NGO)

The Violence Against Women and Domestic Violence Policy Community in Afghanistan

Leaders in Family and Domestic Violence

The interviewees agreed on the names of several organizations that function as leaders in family and domestic violence in Afghanistan: the Ministry of Women's Affairs; the Ministry of Public Health; United Nations organizations such as UNIFEM and UN High Commissioner for Refugees (UNHCR); and national non-governmental organizations such as the Afghanistan Women's Network (AWN) and Afghanistan Human Rights Commission (AHRC). These organizations were recognized as contributors to the achievement of women's rights and prevention of domestic violence in Afghanistan through policy development, advocacy, and education and justice reform. International non-governmental organizations, such as Medica Mondiale which provides education, employment, and counselling as well as training for women who work with victims of violence, received high praise for their work with women impacted by

violence. Participants also identified core international agencies that contribute to health and legal policy development around violence against women and gender-based violence, such as UNIFEM.

However, reservations were expressed regarding the capacity of new governmental and non-governmental organizations to respond and coordinate activities to address violence against women and domestic violence. The excerpts of four different participants expressed common concerns:

> I don't think that the Ministry of Health has done anything special yet, and I can't say if the Ministry of Women's Affairs has done anything either. However, the Ministry of Women's Affairs has done well in publicizing cases on gender-based violence. (National NGO)

> We have to confess that the Ministry of Women's Affairs is one of the weakest ministries, AWN that is a women's coordination body does not performing well either. (National NGO)

> Even the Ministry of Women's Affairs has been very much slow on this issue, despite that this is one of their main objectives and reason to exist. (International NGO)

> There are some NGOs that are engaged in many activities, they lose a center focusing point and thus they remain too far from what they should be doing. Meanwhile there are organizations that focus on a single issue but they lack enough capacity to reach the roots of the problem and finally come with a conclusion for tackling the issue. Thus it is difficult to identify the important organizations. (International NGO)

Health Sector Involvement in Violence Against Women and Domestic Violence

Participants identified the health ministries and health clinics (government, non-governmental organization, and private) as involved in providing treatment for physical ailments resulting from violence and providing health care to women in prisons and shelters. There were no reports of health sector engagement in specific treatment of violence against women and domestic violence. As already stated, there were conflicting reports regarding extent of health sector involvement and collaboration with other organizations. However, organizations concerned with health care delivery at the grassroots level seemed to be primarily focused on increasing awareness in the community that violence is occurring.

> It [an NGO] has conducted workshops on women's health and has raised awareness on how to avoid pursuing the wrong practices that have rooted in Afghan society. Moreover, we have conducted campaigns on elimination of violence against women. (NGO)

Prevention strategies for violence against women and domestic violence are diffused through a wide array of government and non-governmental organization agencies that focus on assessing the determinants of women's health, raising awareness about violence, and improving women's

rights, access to education, and participation in the democratic process as a means of addressing human rights abuses and systemic violence.

The broader health care system crisis in the country was mentioned frequently, and it became clear that the rebuilding of the most basic health care services was required. A focus on escalating rates of maternal and child mortality occupies the women's heath agenda in the country:

> The women in this country are lacking the health care facility at a very broad level. Most of the hospitals are not well equipped and if hospital is equipped then it lacks professional staff to work there. Women do not know much about diseases so that every year mothers and children pass away. Therefore, our organization decided to raise awareness on health too so that we have published pamphlets on HIV/AIDS and circulated them among our beneficiaries and colleagues whom we are working with. In my opinion we should pay attention to mothers' health especially during pregnancy. It is a need to have clinics and well equipped hospitals to secure the lives of women. Meanwhile I suggest some of the awareness raising workshops on health issues. (NGO)

Existing challenges were recognized upon visiting a well equipped and modern maternity hospital outside of Kabul. The facilities were almost empty despite the lack of maternity care identified by women in the catchment area. Ability to access such care was an obvious issue for rural women, both in their rights to the care and feasibility of obtaining transport to the facility.

The integration of maternal health, gender rights, and domestic violence prevention policy agendas was articulated well by a participant from the government:

> We are planning to work on a policy which should help removal of violence in health sector. The ministry is planning to establish a Gender and Rights Pregnancy department. We hope to be a success while planning our structure in the Ministry of Public Health. The aim will be to work on gender issues, inform women on dangers of unplanned pregnancy, educate them on importance of nourishing during the pregnancy period, and ways that can be helpful in eliminating violence. (Government-Health sector)

Participants from non-governmental organizations who deal directly with victims of violence stated that they link with the government ministries around particular initiatives. Not all non-governmental organizations experience difficulties with coordination.

> For the women who were traumatized and have psycho-social problems were treated by the member organizations of [NGO]. There were some training and other activities convened for them to take them out of such a situation. Some of [NGO] members are very much active in health sector. [NGO] itself has very good and friendly connection and relations with MoWA [Ministry of Women's Affairs] and some other ministries. We do not have any problems in coordinating our activities with other groups. (NGO)

Despite the concern regarding the capacity of government departments to respond, the health sector was seen as important to addressing the issue of violence against women and domestic violence. Participants from both the governmental and non-governmental sectors named the Ministry of Public Health as an important partner and supporter of initiatives. The Ministry of Health was mentioned, but their role was not clear. The interviews revealed that the health sector was responding to the plight of women primarily by addressing maternal and child mortality and supporting the activities of other organizations through the provision of space in health clinics or assisting in the printing and dissemination of information.

When the theme of multisectoral collaboration arose, participants articulated the opinion that linkages between groups concerned with this issue must be established and that women's voices were needed to offer a clear understanding of the problem of violence against women.

> The presence of judges and lawyers from each court; especially family court, the Ministry of Women's Affairs, the Ministry of Health and the Independent Human Rights Commission are important since they are all the main players and actors on women's domestic violence and health issues. (Government-Justice sector)

> First of all, health experts have to meet with women representatives. In order for a better decision to be rendered, the health experts should allow and encourage women to share their problems and thoughts. (International NGO)

Linkages Between Violence Prevention and the Health Sector

Based upon the responses of participants, linkages within the health sector appeared to be facilitated in three ways: 1) in UNIFEM meetings; 2) through the Ministry of Women's Affairs; and 3) informal, locally orchestrated relationships for mutual benefit between disparate groups of international non-governmental organizations. The linkages are supported by monthly meetings hosted by UNIFEM, wherein research and program developments related to violence against women and domestic violence are discussed. Minutes from the meeting are circulated to the whole group. These meetings are restricted to Kabul, but a very wide range of participants are invited, including UNHCR, Amnesty International, national and international non-governmental organizations, and government representatives from the Justice and Health Ministries.

Non-governmental organizations such as the Afghan Women's Network continue to expand and link with health-related activities through sharing clinic space in both rural and urban areas. This sharing of venues is one way in which programs share resources. Co-locating provides an opportunity for communication with and access to women who come for other health-related visits such as child immunization. In the excerpt below, a health sector NGO gave an example of an existing collaboration where groups concerned with women's health education work together. Using existing infrastructure may enable future programs on violence against women and domestic violence to be rolled out.

> We hold our training in coordination and collaboration with UNICEF and WHO. These organizations prepare the training material and flip charts for us. While in conducting some of the workshops especially on TBA [traditional birth attendants] the Ministry of Public Health assists us too. (NGO)

During meetings with members of the policy community, we were introduced to a variety of websites that are used to communicate information about programs and activities. The need for increased web-based communication was mentioned frequently as a means to facilitate linkages and communication between individuals concerned with violence against women and domestic violence. Barriers such as problems with power shortages, internet sever capacity, and outdated computer hardware and software were all mentioned as impeding the formation of relationships and structured links. The population is dependent on cellular phones for communication, but must also contend with frequent breaks in network access. Internet cafes exist in Kabul, but women must be careful in such public places and people must be careful about what web pages they are seen to be viewing.

Women's Participation in Health and Other Policy Development

A common theme across the interviews was the desire to have women's involvement in health policy development and with policy discussion and public governance in general. However, many associated barriers were identified. These barriers included: problems with communication between urban and rural areas; the primary focus of international activity being centered in Kabul; access to women to obtain data; developing culturally sensitive care; and translating women's input into policy and then translating the policy to action and necessary programs. Strategies for accessing and involving women included using voter and clinic visitor registration lists. All participants suggested that there needed to be a greater cooperation between the Ministry of Women's Affairs and non-governmental organizations involved in delivery of health services. However, few solutions were suggested to address the problem of gathering women's perspectives and using them to generate policy. The excerpt below gave some insight into the participant's vision for women's participation and how communication between women and the decision-makers might occur.

> Moreover, with MoWA [they] are working with 12 other ministries on policy and women's role, right of men and women, women's role in the reconstruction and rehabilitation of the country. With MoWA we work in two levels one is to contribute and include our inputs in the policies made in the government to make sure women are included or considered while designing the strategy and the other is organization gender and women's rights awareness workshops to build up the capacities. (National NGO)

Another participant echoed the concern that women's involvement is often restricted to Kabul, but also gave some insights into possible limitations of the current trend to access women's ideas though workshops aimed at building understanding of human rights and a democratic process. A large number of agencies were involved in education programs seeking to prepare women for voting in the first National election and participation in local decision-making. It remains unclear as to how these activities will or will not translate into policy development focussed on violence against women and domestic violence.

> The ideas on development of a policy should be collected from all across Afghanistan. Kabul is not the whole Afghanistan. Women should be asked for what points they want to be included in the policy. The policy should be made practical so it does not remain a piece of paper, but a worthy document that brings

> statement to action; at the end of each policy, the punishment for the disobeyers should be clearly mentioned. (NGO)
>
> We can collect women's idea through workshops and raising awareness seminars. We could inform 98,587 people in presidential elections. We are going to have workshops for parliament elections. So we can collect people's ideas during these meetings. And we have the ability of doing this task, this method is better than collecting the ideas of 20 people in the workshop. People should be invited from village hospitals; everyone should be given a chance to share her ideas and make a final strategy in which everyone's ideas should be included. (NGO)

The need for culturally and gender sensitive health care was also discussed by participants. In the excerpt below, a participant discussed the need for women's participation in health policy and service delivery.

> We have to collect the ideas before establishing a health center which is great. We have to ask about the women' problems, the public facing difficulties in health sector, the distance between two provinces should be considered. The activities of that center should be according to the cultural belief of people. For instance, women would like to be treated and checked by a female [doctor] rather than a man [doctor]. In case these cultural norms are not respected then the women despite having a hospital will not have access to such health care services. (NGO)

One particular phenomenon was the way in which government ministries operated at a grassroots level, as a point of entry for individual women who were seeking assistance as or for victims of violence. This is very different from the usual points of entry in North America or Australia where women have multiple services from which to seek help. Organizations at all levels, be they local non-governmental organizations or government ministerial offices, accepted individual petitions from women for help or refuge. For example, we witnessed a senior officer in the Ministry of Foreign Affairs lobbying for a safe haven for a woman in need. The Ministry of the Interior (responsible for women's prisons) and the Ministry of Justice (responsible for legal adjudication) assured the researchers that they too were engaged in dealing with individual cases. The communication between these divergent groups appeared to be through direct conversations and petitions. Following the rapid formulation of ministries and departments in the interim and then elected government, each was starting to carve out mandates and roles. New governmental and non-governmental resources were being developed rapidly, revealing an emergent, fluid, and dynamic network of individuals and agencies. Most ministries had an expatriate specialist in gender as a senior advisor.

DISCUSSION

There is a widespread recognition both nationally and internationally that Afghan women are among the most oppressed populations of women and that violence is a clear part of the oppression. Whether the violence is the basis for a restriction on human rights or is the outcome of a lack of human rights can be clarified if one takes a population health approach. Population or public health is a broad trans-disciplinary approach to understanding the determinants of human health, especially the interaction of physical and social environments, over the life-

course, at both individual and community levels, in whole societies. Through the population health lens one can see that violence against women can only be maintained if their rights to equality in education, justice, autonomy, and security of the person are denied at a population level. Therefore, violence is the result of a loss of human rights at the social level. Afghan women have made it clear through non-governmental organizations and government spokespeople that regardless of history or historical interpretations of cultural norms, violence against women is not acceptable. But violence, of all kinds and throughout the life cycle, continues to be used to silence women and to limit their power through limiting their access to social capital and financial capital. On the individual level, the opposite may be true, that is, individual women who have the least access to rights may be more vulnerable to violence than women who have, for instance, obtained an education and employment. All women, however, live with the knowledge that they may be 'kept in their place' through violence. Women's efforts to organize and act collectively are restricted by violence and the threat of violence; however, the women of Afghanistan take huge risks in the hopes of improving the situation for future generations.

The preliminary analysis suggests a low level of engagement on the part of the health sector in domestic violence prevention, either primary, secondary, or tertiary (treatment) focused. However, defining the boundaries of the health sector was challenging and it became necessary to understand violence against women and domestic violence in Afghanistan within the context of a dynamic and rapidly evolving community of governmental and non-governmental organizations. The multiple points of entry into support for women operated in a setting where no laws prohibiting violence against women existed and few formal resources such as shelters were available. In light of the scale of the problem, it is impossible to conceive that this compassionate individual level response can be sustained; however, it does serve to educate first hand a cross-section of people in decision and policy making positions about the plight of women. The new connections, motivations, and leadership displayed by many members of the policy community suggest that violence against women and domestic violence is being discussed and diverse groups are attempting to develop a response to the problem. As in other countries, women and women-centred NGOs provide the primary leadership in the efforts to end violence against women and children; however, there are men of good will who are willing to work alongside these leaders. The best ways to engage men in this movement was identified by all countries in the study as a pressing need.

Very little reliable demographic data exists in the country as a result of war and massive refugee migration. There is no mechanism for gathering information of the prevalence of domestic violence or violence against women or reporting on the impact of violence on women's health. Consequently the format of this report differs considerably from the other country reports from Bangladesh, Thailand, Canada and Australia in several important ways. It was necessary to rely more heavily on documentary resources and reports than on interviews alone. Whereas other country reports were able to articulate a history of domestic violence prevention and treatment activities, these are only now being envisioned in Afghanistan. Thirty-five years of war has resulted in the decimation of health, education, judicial, and political infrastructures. Terms of reference such as gender-based violence, policy community, and health sector participation were unfamiliar to some participants and did not readily translate to the Afghan cultural context despite attempts by the research planning team to make them relevant to the setting.

The report reflects the unique and particular problems associated with conducting research in Afghanistan that are mere representations of the challenges facing those trying to improve women's rights in Afghanistan. Many do not have the financial resources of a reliable professional level salary. As Canadian researchers we learned we were privileged to know when and how much we would be paid. Foreign professionals had access to a standard of living to which few Afghans could aspire. In addition, expatriates have rights and privileges, thus personal power, granted by their citizenship in other countries. Both the visiting scholars and the local research team faced political, human resource, language, and security challenges, but as visitors we knew it was temporary. Although Afghan colleagues worked diligently to conduct interviews and gather data from a broad cross section of members of the domestic violence policy community, participants were not at liberty to speak freely and sometimes found the interview questions difficult. The need for complete anonymity prevented the researchers from fully discussing participants' comments or making any attributions to particular individuals, organizations, or sectors. Current, accurate information regarding the structure of the health system and responses to domestic violence was difficult to obtain due to the fluidity of the situation in Afghanistan and the huge number of international players on the ground. This silencing is a major source of control of women and indicative of how far the human rights agenda must be moved to improve the situation of women in Afghanistan. The desperation felt by individual victims in this context is captured in the rising suicide rates.

Participants reflected a common dilemma of women's organizing, that is whether to work on the inside of government or as outside advocates. The hopes placed by some in creation of government structures, such as the Ministry of Women's Affairs, appear to have diminished with the realization that the degree of power of the Ministry reflected the degree of power of Afghan women. Experience in other countries, however, has shown that working from both inside and outside of government can have beneficial effects for women's rights.

How Afghanistan learns from the experience of other countries in addressing violence against women will be reflected in responses. For instance, the health system response that other issues (e.g., maternal health) are a greater priority is not surprising as it represents the behaviour of the health systems around the world from which consultants would have been drawn. In places like Canada, there is now some discussion about primary prevention of violence against women, but this does not emerge from the health systems. Given that a lack of women's rights has been suggested to be the basis of violence against women, Afghan NGOs might be advised to focus on primary prevention and achieving education and economic freedom for women, knowing that freedom from violence will eventually follow; however, experience in other countries has shown that this is not possible and that a large sector will be drawn to saving lives today.

CONCLUSION

This research has begun a process of identifying the key players in an emerging violence against women and domestic violence policy community in Afghanistan. These individuals work within organizations that face a desperate set of circumstances in an ongoing conflict in a country where virtually all government and civil society structures have been destroyed and are only slowly being rebuilt. The participants were united in their characterisation of the human rights crisis facing women and the huge challenge of responding to their health and security needs. International solidarity is needed to ensure that the signing of CEDAW is translated into the

commitment of resources to the prevention and treatment of violence against women and domestic violence.

The scope of the problem outlined by the research participants is echoed by Ertürk (2006) who stated that Afghanistan represents a complex situation where violence against women and domestic violence must be viewed through the lens of war, state sanctioned violence, customs, traditions, trafficking, and street violence. The scope of these problems is daunting and measures to address this continuum of violence are constantly hampered by ongoing insecurity in the country. Despite the enormity of the situation, rebuilding is occurring and highly talented leaders are being developed at all levels of the Afghan government and civil society. International and national development efforts to build a health care infrastructure are moving forward and the Ministry of Public Health is making remarkable progress in rolling out the basic set of health services. Work to improve access and address the educational needs of women is progressing very slowly. However, the willingness of many Afghans to speak openly for the first time about the problem of violence is encouraging. We met many profoundly committed and courageous people who called for additional support to further research and program development aimed at strengthening the violence against women and domestic violence policy community. It is the hope of the WDVHP team to continue working with our Afghan colleagues toward this end.

EPILOGUE

On June 19 2008, the United Nations Security Council passed a resolution calling for the end of the abuse of women during conflict. Support for our conclusions is provided in the statement to the Council, as recorded in the minutes of the meeting, by Zahir Tanin, representing Afghanistan. It reads as follows:

> Armed groups often used violence against civilians, especially women, as a deliberate war tactic. Under the Taliban regime, atrocities against women had occurred constantly, such as the "slaughtering" of women at Kabul stadium and their "bludgeoning" in the street for "un-virtuous behaviour". Sexual violence was not systematically employed by armed groups in Afghanistan in times of war because of certain cultural limits, but it was, indeed, being used by some individuals and groups as an instrument of war. It was also true that, in both conflict and post-conflict situations, violence against women extended beyond sexual violence. The international community should duly acknowledge the wide variety of violence inflicted on women.
>
> He said that, since the fall of the Taliban, the Government of Afghanistan had made considerable progress in creating a secure environment for women, where their rights were protected and where their participation in decision-making bodies and in the peacebuilding process was guaranteed. The Afghan Ministry of Women's Affairs was leading that effort, through the ministerial task force that it chaired. The disarmament, demobilization and reintegration process was being seized as an opportunity to minimize violence against women and to create an environment where they felt empowered. More female law enforcement officers were being recruited, and the police were being given gender-sensitivity training.

Women were also being hired to staff the police family response units, and given training to deal with domestic violence and to respond to female victims of crime.

He said the escalation of violence and insecurity in some parts of the country, as a result of terrorist activities carried out by the Taliban and Al-Qaida, had hampered the implementation of the rule of law, rendering women vulnerable to all forms of violence. Violence was being used against women by those two groups to force their retreat from public activities and to limit their access to health care and other social services, especially in the south and east. It had particularly affected girls' school attendance, and both female students and teachers had been attacked and threatened. The legacy of the long conflict, including easy access to weapons, instability and rampant poverty, manifested itself in self-immolation, forced marriage and domestic violence. As such, he asked for help from the international community to strengthen national capacities to improve economic and social conditions within the country, while requesting that peacekeepers be given gender-sensitivity training. (Security Council, 2008)

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