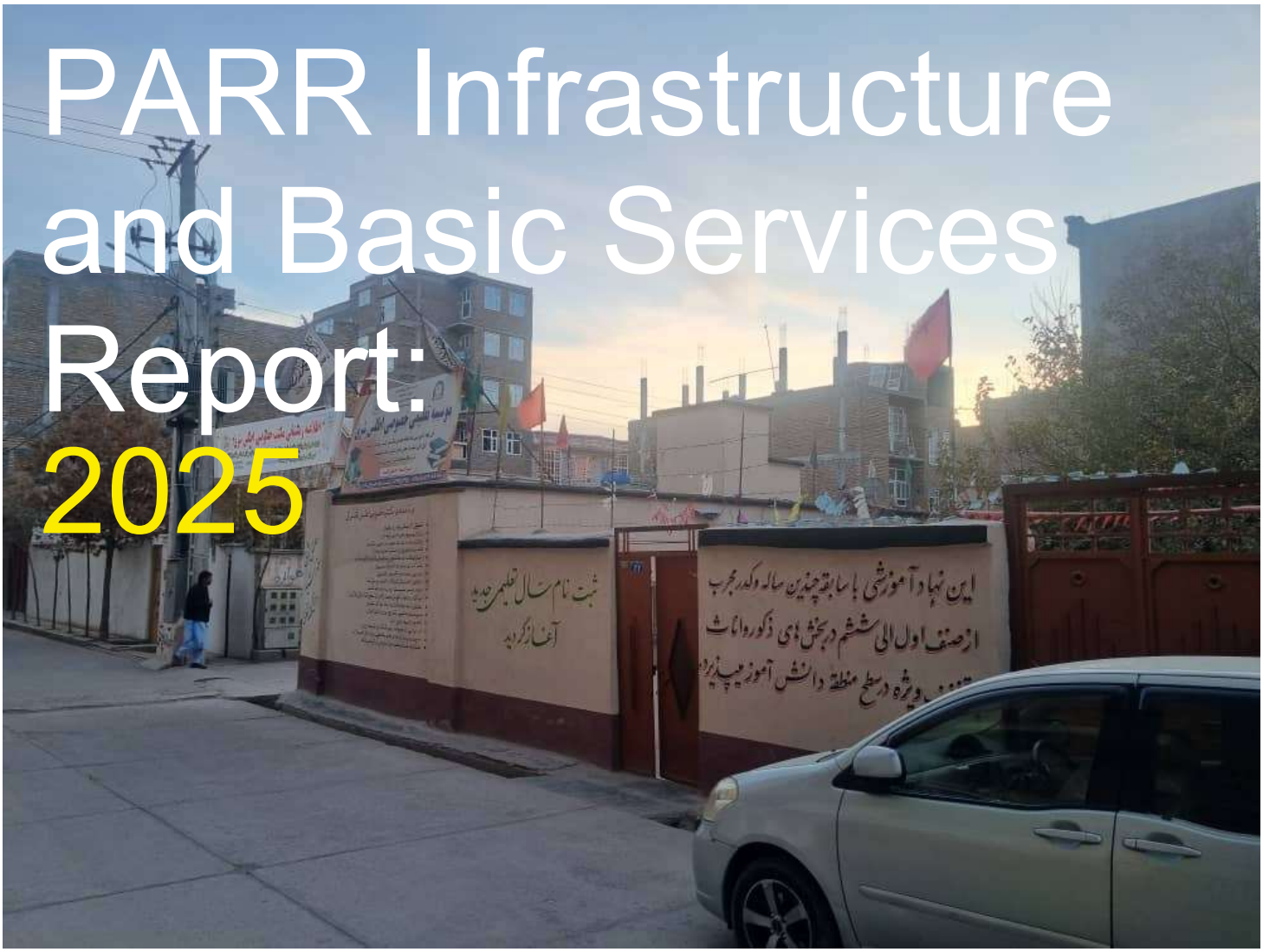
PARR Infrastructure and Basic Services Report: 2025



Contents

List of Acronyms **3**

Executive Summary **4**
Methodology 4
Key Findings 4

Introduction **6**

Methodology **7**
Data sources: 7
Analytical framework 7
Limitations 7

Healthcare **8**
Availability 8
CARRYING CAPACITY OF HEALTHCARE PROVIDERS 8
Existing healthcare availability and capacity 8

Education **15**
Availability 15
CARRYING CAPACITY METHODOLOGY 15
Capacity calculations 16
Access 18

Household infrastructure and utilities **23**
Shelter and water 23
Electricity and heating 24

Recommendations and conclusions **26**

Annexes **1**
Annex 1: Clinics and teachers needed by PARR district to reach ideal, strained or maximum capacity operating levels for health and education 1

List of Acronyms

BHC	Basic Health Centre
CBE	Community Based Education
CHC	Comprehensive Health Centre
CSO	Civil Society Organisation
DfA	De Facto Authorities
EERA	Emergency Education Response in Afghanistan
FGD	Focus Group Discussion
HCT	Humanitarian Country Team
HER	Health Emergency Response
IASC	Inter-Agency Standing Committee
INGO	International Non-Governmental Organisation
NGO	Non-Governmental Organisation
NNGO	National Non-Governmental Organisation
NSIA	National Statistics and Information Authority
OCHA	United Nations Office for the Coordination of Humanitarian Affairs
PARR	Priority Areas of Return and Reintegration
PSEAH	Prevention of Sexual Exploitation, Abuse and Harassment
SEAH	Sexual Exploitation, Abuse and Harassment
SEVA	Socio-Economic Vulnerability Assessment
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nation's Children Fund
WASH	Water, Sanitation and Hygiene
WB	World Bank

Executive Summary

Methodology

This data brief evaluates the state of infrastructure and basic services in Afghanistan's Priority Areas of Return and Reintegration (PARR), with a focus on healthcare, education but also investigating household shelter, water and utilities infrastructure. Using primary and secondary data, it assesses service capacity as well as access and quality constraints and their implications for policy and programming. The evaluation methodology builds on a framework developed by Samuel Hall with UNHCR for high-return areas in South Sudan, in which infrastructure adequacy and priority areas for intervention are analysed through integrating population data with international and national service delivery standards.

Key Findings

1. **There are significant disparities in healthcare service provision across the PARR areas.** It is estimated that 154 new healthcare clinics would be required in the North East region to meet ideal service capacity thresholds, while no new clinics would be required in the Central Highland region.

2. **Education infrastructure is under severe strain in most PARR districts,** with only 4 districts found to be operating at an ideal service capacity. The South and North East regions are most underserved, requiring 13,190 and 8,977 teachers respectively to reach ideal capacity standards.[1]

3. **Households with disabled members have poorer healthcare access.** While IDPs and Returnees are not less likely to report having access to health services than host community members, households with a disabled member are 25% less likely to report access to a functioning medical facility when factors such as location, head of household and displacement status are taken into account.

4. **Access to education is impeded by a variety of economic and social factors.** Households below the poverty line are 35% less likely than households above the poverty line to have a child enrolled in school, while households with no educational attainment are 79% less likely to have a child enrolled than household in which a member has a bachelor's degree.

Photo 1: Health clinic in Laghman province (Samuel Hall)

[1] *The specific threshholds can be found within the separate Health and Education sections*

5. **IDPs and returnees are less likely than host community members to have a child attending school** by 14%. However, IDPs and returnees are also more likely to report satisfaction with the education services they receive, potentially highlighting the high demand for equal education access.

6. **Households below the poverty line are 47% less likely to report sufficient access to water than those above the poverty line,** highlighting that adequate access to water is highly correlated with structural and income inequality

Introduction

This data brief provides an assessment of infrastructure and basic services in Afghanistan's Priority Areas of Return and Reintegration (PARR). Focusing on healthcare and education provision, it utilizes both primary and secondary data sources to evaluate current service capacities and identify gaps. The brief also examines access challenges, population dynamics, and the implications of these findings for programming and policy interventions.

The purpose of this exercise is to evaluate the capacity of existing infrastructure to meet the needs of populations and to provide actionable recommendations for improving service delivery. By analysing current conditions and comparing them to global standards, the report highlights areas where: investments in infrastructure and services are most urgently needed. This evidence-based approach seeks to strengthen reintegration efforts, foster community resilience, and enhance the long-term sustainability of solutions for displaced populations.

Photo 2: Clinic in Mehtarlam PARR district, Laghman (Samuel Hall)

The methodology employed in this report is grounded in an approach Samuel Hall developed in collaboration with UNHCR in South Sudan to assess absorption capacity. This framework, tailored to the Afghan context, integrates population data with international standards for service delivery to evaluate the adequacy of infrastructure and identify priority areas for intervention.

The report draws from a range of data sources, including the latest NSIA (National Statistics and Information Authority) statistical yearbook, REACH PARR mapping exercises, and surveys conducted by organizations such as OCHA, UNHCR, Samuel Hall, and others.

Methodology

This report is built on a combination of primary and secondary data analysis to assess the availability, accessibility, and quality of infrastructure and basic services across Afghanistan's PARR districts.

Data sources:

Primary data sources include the following:

1. NSIA Statistical Yearbook (2023-2024): Provides key demographic and population statistics for PARR areas, including IDP and returnee proportions.
2. REACH PARR Mapping (2024): Supplies data on healthcare and education infrastructure, including the number and type of facilities, operating capacity, and carrying thresholds.
3. UNHCR Protection Monitoring and Infrastructure Projects (2019-2024): Offers information on completed projects in PARR districts.
4. Samuel Hall's UNICEF Collaboration (2024): Contributes findings on gendered access to healthcare and education across Afghanistan.
5. UN-Habitat Spatial Profiling (2022 and 2023): Includes insights into urban infrastructure and service availability in Jalalabad, Kandahar and Herat.
6. UNICEF Multiple Indicator Cluster Survey (MICS) 2022-2023: provides data into enrolment figures and education access across Afghanistan.
7. Samuel Hall and World Bank's Afghanistan Energy Study (2023-2024): Data on shelter infrastructure, access to energy and heating in five provinces and ten PARR districts.

Secondary data were drawn from reports and publications that contextualize findings, offering additional depth to the analysis. These sources provided international benchmarks (e.g., Sphere Standards) and supplementary data on healthcare and education carrying capacities, as well as broader regional trends.

Analytical framework

Infrastructure data were compared against international and national thresholds for healthcare and education capacity. Sphere Standards were used to define benchmarks for healthcare facilities, while teacher-student ratios were employed for education capacity assessments.Mapping tools were used to visualize disparities in infrastructure across PARR districts. Regional and district-level variations were assessed to highlight underserved areas.Disaggregated data from OCHA and REACH allowed for comparisons between IDP, returnee, and host populations, providing insight into how displacement impacts access to services.Data from focus group discussions (FGDs) and key informant interviews (KIIs) conducted in previous studies added context to quantitative findings, highlighting barriers such as distance, cultural norms, and operational challenges.

Limitations

While the report aims to provide a comprehensive overview, several limitations should be noted:

- Some datasets, particularly on education, lacked disaggregated information, such as the number of teachers per facility.
- Healthcare facilities were analysed under broad categories (e.g., clinics and hospitals) without differentiating between levels of care (e.g., basic versus comprehensive healthcare).

Regional and cultural differences were not fully accounted for in all datasets, potentially impacting the uniformity of thresholds applied.

Healthcare

Availability

Since 2022, REACH has been collecting data on operating facilities within 75 UNHCR designated PARR areas. Over several rounds, last in 2024, it has identified 534 healthcare clinics and 104 hospitals. Using data gathered by REACH in combination with international standards for health and education, *under the assumption that all operational facilities can fulfil their base level functions*, the following presents an estimate of the current strain on available services in the PARR locations according to estimated population levels and expected facility carrying capacity.

Carrying capacity of healthcare providers

International SPHERE standards serve as a benchmark for determining the minimum acceptable carrying capacity of healthcare facilities in humanitarian settings. These standards account for variations in the size, service availability, and geographical context of facilities. Clinics and hospitals are assessed using distinct thresholds, reflecting their differing roles and capacities. For clinics, thresholds vary between rural and urban areas to account for population density and the larger catchment areas typically seen in rural settings. In this analysis, the ideal threshold for clinics corresponds to the SPHERE standard for urban facilities, while the maximum threshold reflects the capacity expected of rural clinics. Similarly, for hospitals, the maximum capacity threshold aligns with the expected capacity of district or rural hospitals, ensuring a realistic and context-sensitive evaluation of healthcare infrastructure.

The specific thresholds are found in the table below:

Facility	Operating capacity	Carrying capacity threshold (number of patients in catchment area)
Clinic	Ideal	10,000
	Strained	35,000
	Maximum	50,000
Hospital	Ideal	100,000
	Strained	175,000
	Maximum	250,000

Nota bene: The data does not differentiate between different types of clinics (ie. BHCs or CHCs). Consequently, the threshold for all clinics is set equally. As different types of clinics may have different carrying capacities this is a noted limitation.

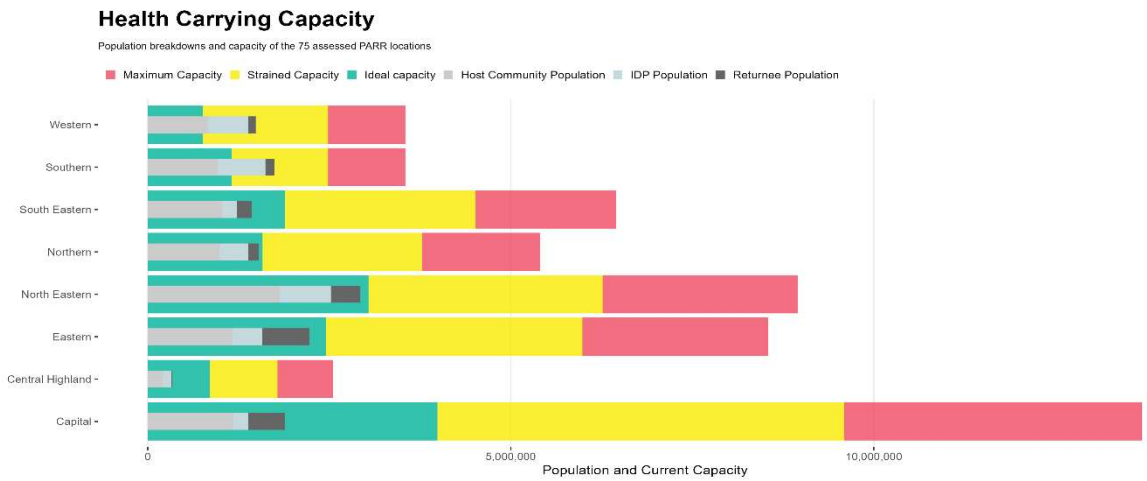
Existing healthcare availability and capacity

Our analysis reveals significant disparities in healthcare service provision across the PARR areas. Notably, only the Capital and Central Highland regions avoid having any districts operating beyond maximum capacity based on current healthcare infrastructure.[2]At the regional level**, the Western and Southern regions exhibit the greatest strain on healthcare services**. This aligns with their status as

[2] *in the Central Highland region, this is primarily due to its lower population levels rather than an extensive healthcare network*

the regions where internally displaced persons (IDPs) constitute the highest proportion of the population (37%).[3]

Figure 1: Health operating capacity at a regional level (based on PARR districts)

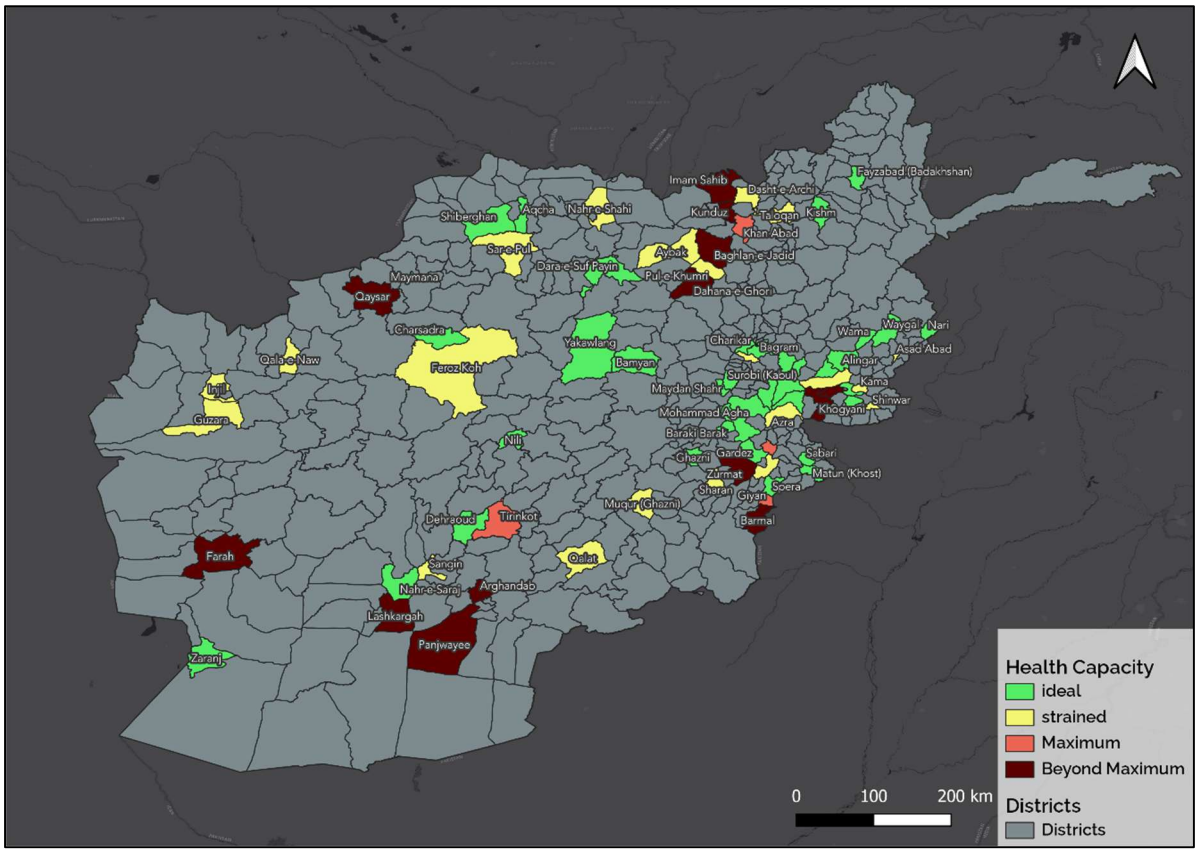


At the district level, many PARR locations are clearly underserved in terms of healthcare infrastructure. Thirteen PARR districts are currently estimated to operate beyond the maximum capacity of their health services, with an additional four districts at maximum capacity. The North Eastern and Southern regions exhibit the highest prevalence of districts exceeding capacity, with four and three districts, respectively, underscoring the critical need for enhanced healthcare infrastructure in these areas.

The outlook in the North Eastern region is skewed by the concentration of hospitals in Badakhshan, where 17 hospitals, including 15 in Faizabad, create an apparent surplus. However, outside of Badakhshan, there is a pronounced shortage of healthcare infrastructure, leaving many households with limited access to functional services.

[3] *Population proportions derived from figures used for the REACH 2024 PARR mapping*

Map 1 Health capacity across the different PARR districts



Demographic analysis indicates that the number of internally displaced persons (IDPs) and returnees in a given location does not significantly predict healthcare operating capacity when regional factors are accounted for. This suggests that geographic location is a more crucial determinant of healthcare strain than the displaced or repatriated population size.

In two districts—Surkh Rhod (Nangarhar) and Barmal (Paktika)— there is a maximum of one BHC (basic health centre) available, leaving populations of 323,924 and 80,574 almost entirely dependent on traveling to neighbouring districts for healthcare. In Surkh Rhod, many residents are expected to seek treatment in Jalalabad. However, for those in the southern and central parts of the district, the distance to healthcare facilities is likely to be a significant barrier.

Targeted interventions by development actors are essential to address these critical gaps. Annex 1 provides estimates of the number of clinics needed within each PARR district to meet various operational capacity thresholds. The accompanying table illustrates the clinic requirements for each district within a region to achieve ideal capacity levels.

Table 1: Clinics needed to reach different threshold levels

Region	Population	Clinics present	Hospitals present	Clinics needed for each district to reach ideal capacity	Clinics needed for each region to meet strained capacity	Clinics needed for each region to meet maximum capacity
Capital	1,885,908	149	25	6	0	0
Central Highland	342,285	16	7	0	0	0
Eastern	2,226,435	96	15	80	13	8
North Eastern	2,928,513	54	25	154	23	9
Northern	1,524,987	58	10	29	2	0
South Eastern	1,435,475	69	12	38	6	4
Southern	1,747,892	26	9	79	11	2
Western	1,488,776	66	1	73	9	6
Grand Total	**13,580,271**	**534**	**104**	**459**	**64**	**29**

As shown by the table, **the greatest number of clinics are required in the North Eastern region (154) to meet an ideal operating capacity due to its large population size**. On the other hand, due to a more limited population no districts in the Central Highlands require further infrastructure developments. Across all locations, to reach at least a maximum operating capacity across all districts a further 29 clinics would be required.

Access

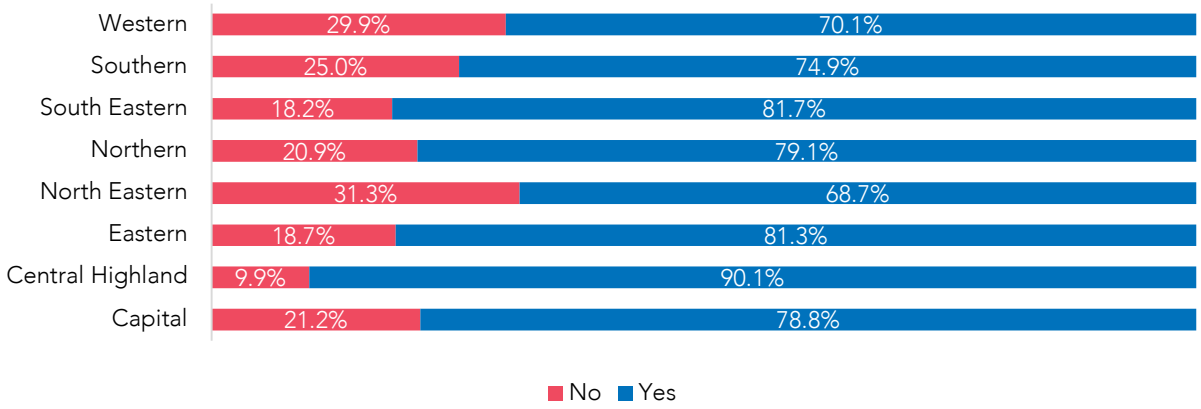
Acknowledging that availability of services is only one component of access, other sources such as the REACH SEVA 2024 data collection exercise[4], a Samuel Hall study on gendered access to healthcare and education provide greater detail into the accessibility and quality of basic services in PARR areas.

REACH SEVA data reveals stark disparities in healthcare access across PARR districts. Households in Imam Sahib (North Eastern region) and Agrandab (Southern region) reported the lowest access levels, with 89% of households unable to access healthcare in the past three months. These findings align with evidence that infrastructure in these districts is operating beyond its maximum capacity.

In Tagab, despite having sufficient healthcare infrastructure (one hospital and six clinics), 61% of households reported a lack of functional access to healthcare. Factors such as distance (cited by 70% of respondents) and shortages of medicines (52%) were identified as major barriers, underscoring the gap between facility availability and actual access.

Figure 3: Households in PARR areas reporting that they have had access to a functioning healthcare in past 3 months

[4] *This dataset contains information on education and health access across 10,070 households in 75 PARR locations.*



Neither displacement or economic status (above or below poverty line) were found to be significant in predicting access to healthcare when factoring for location, the gender of the head of household and presence of a disabled household member. **However, households with a disability were 25% less likely to report access to a functioning medical facility when holding all other factors constant**. The main challenges to health access for men and boys and women and girls were largely consistent across all regions, with **a lack of medicines, distance and limited service availability identified as the main access challenges**. Some obstacles were more geographically dependent. In PARR districts across the Southern and South Eastern regions, women were most likely to face female medical staff shortages (30% and 34% of respondents in these locations respectively). Long distances to the health centre most commonly reported in the North East region (over 50% reporting this to be an issue), supplementing the finding that health centres in this location are centralised in a few key areas and unequally distributed.

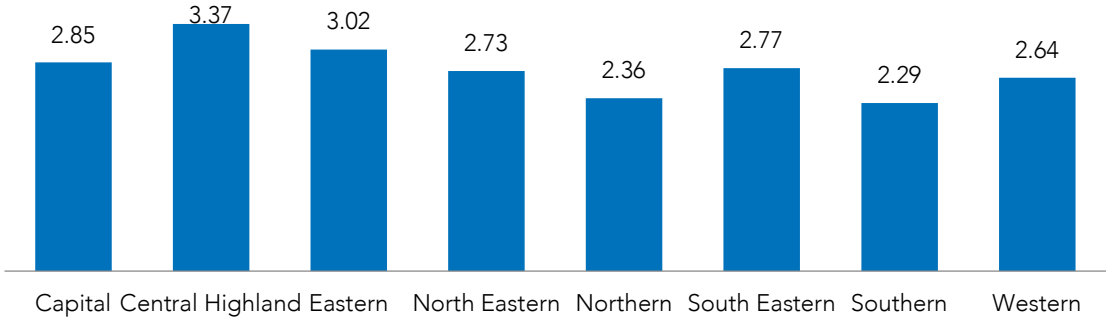
Findings from a recent Samuel Hall study on healthcare add substance to the challenges faced in accessing medical care in many PARR districts. In Nimroz, one hospital administrator highlighted that a mixture of long distances and insufficient road infrastructure provided unique challenges in transferring patients: '*The road is in extremely poor condition, making it very difficult for us and our colleagues to reach the center. At times, we have even lost our way, or our vehicles have gotten stuck in the sandy terrain. This creates serious challenges in transferring emergency patients, and in some cases, it risks their lives. (KII, Male, Manager Health Center, Nimroz)*'

Last, access challenges were found to be unevenly distributed between men and women. The requirement for travel with a mahram adds significant constraints to women who need to seek medical services as noted by this respondent in Laghman: '*In our community, it is considered necessary for women to have a mahram (a male relative) present when receiving healthcare services. If a mahram is not present, women are deprived of receiving these services. (FGD, Female, Laghman)*'

Quality

When asked to rate the quality of the healthcare in their location on a scale of one to 5, the lowest ratings **were received in the Northern and Southern regions**. Complementing the finding that respondents in these locations were the most least likely to report that there were no barriers to accessing health facilities (5% of respondents in both regions).

Figure 4: Households in PARR areas satisfaction with local health services (scaled from 0 to 5)



While displacement category was not a significant predictor of healthcare satisfaction, **gender of the respondent and presence of a disabled member were**, with female respondents more likely to report a higher level of satisfaction (by an average of .4). On the other hand, respondents in households with a member with a disability reported lower levels of satisfaction by an average of .2 (both relationships are significant) when controlling for location.

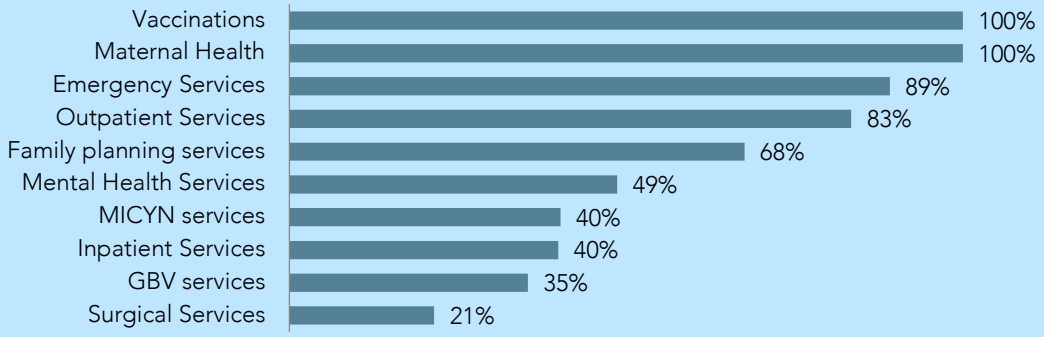
Within the Samuel Hall health and education study, as highlighted by the REACH 2024 SEVA data, it was found that many smaller facilities did not have the capacity to accommodate many patients and lacked equipment and specialist medical professionals: '*I am poor and I don't have money, so I came to this clinic multiple times. Once I had an ear problem and when I came to this clinic the doctor said we do not have an ear doctor. (FGD, Female, Parwan)'*

In some locations such as Kabul, it was found that limited medicine stocks forced patients to fulfil scripts themselves from pharmacies, adding a considerable financial burden: '*There is an issue when two patients from the same household come; they only give a prescription for one patient and do not attend to the other. They say you have brought everyone from your house to the clinic. They say that at one time, we only give a prescription to one member of a family. (FGD 1, Housewife, Nawah Health Clinic, Kabul)*

Limited availability of services in healthcare in Afghanistan

A 2024 Samuel Hall survey of 122 health facilities across 31 provinces highlighted severe service and staffing limitations. Most facilities provided only basic services, such as vaccinations, maternal health, emergency services, and outpatient care. Inpatient care, surgical procedures, and specialized nutrition services were largely unavailable.

Figure 5: Services provided in 122 hospitals across 31 provinces surveyed by Samuel Hall in November 2024



Staffing levels were critically low, with an average of only 2.6 general practitioners and 4.2 nurses per facility. Key roles such as psychosocial support workers, paediatricians, and surgeons were scarce. Female medical staff were particularly underrepresented, with fewer than one female general practitioner per facility on average.

Education

Availability

REACH has mapped 2,675 government schools, 1,664 madrassas and 370 private schools in the 75 UNHCR designated PARR areas. Using data gathered by REACH in combination with international standards for education, *under the assumption that all operational facilities can fulfil their base level functions*, the following presents an estimate of the current strain on available education services in the PARR locations according to estimated population levels

Carrying capacity methodology

For this analysis, secondary and high school education[5] has been excluded due to the current gendered ban on higher education for women and girls. **Primary education was therefore used to be indicative of education infrastructure available to the whole school aged population.** To gauge carrying capacity of primary education, thresholds were devised using both international standards and national education statistics from the 2023-2024 NSIA yearbook**.** In contrast to health, educational capacity is derived from the number of teachers present instead of the type of facility, as student to teacher ratios are more consistently used to determine overall education capacity.

Deriving the number of teachers per PARR district

From the REACH 2024 and 2023 PARR mapping exercises, data is provided on the number of government, private schools and madrassas in the respective PARR areas. However, the number of teachers or type of school (primary, secondary) is not defined. To derive the number of teachers and type of schools available in these areas, the NSIA 2023-2024 statistical yearbook was used to calculate on average what proportion of schools in a given province are primary (for government and private schools). The same source was used to derive the average number of teachers in each province for primary government, private education centres as well as madrassas. These figures were used to input the expected number of teachers per school or education centre.

To establish the primary school aged population, OCHA disaggregated population statistics were used to determine the proportion of primary aged populations per province (aged 7-12).[6] This proportion was used to infer the school aged population based on the PARR population figures as calculated by REACH for the 2024 PARR mapping exercise. For these calculations, **the total number of primary aged children are used over the number of children enrolled**, as it is expected that each child should have the opportunity to receive education regardless of enrolment status.

[5] *In Afghanistan, secondary and high school refer to grades 7 through twelve. This analysis only takes into account primary school which includes grades 1 through 6.*

[6] *NSIA, 'Statistical Yearbook: 2023-2024', July 2024*

Using these standards, the following thresholds have been allocated for education in this analysis, with the ideal threshold for teachers being the internationally recognised ideal student to teacher ratio (25:1)[7], with the strained capacity threshold matching the average student to teacher ratio in Afghanistan in 2023 according to the NSIA yearbook (48:1). The maximum threshold is therefore set as double the average student to teacher ratio in Afghanistan in 2023.

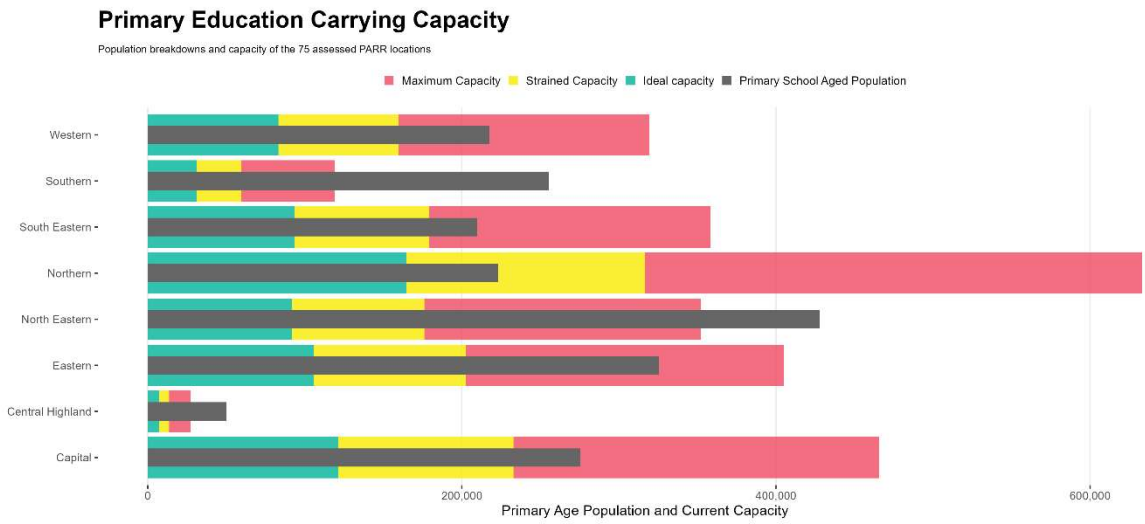
Operating capacity	Carrying capacity threshold (number of students per teacher)
Ideal	25:1
Strained	48:1
Maximum	96:1

Capacity calculations

Taken at a regional level, **almost all districts in PARR face education services that are either at or above maximum capacity.** Subsequently, 40% of all PARR districts are operating beyond maximum capacity in relation to their assumed primary education infrastructure, while 33% are operating at maximum capacity. **Only 4 districts are estimated to be operating in the ideal range**, with capacity to meet a teacher to student ratio of 25:1 for the entire primary school aged population, 2 of these districts are located in the Northern region, with one in the Capital and another in the East region. The Central Highland and Southern regions appear to be under particular strain in regards to their primary education capacity, where all PARR districts are classified as operating at either maximum or beyond maximum capacity.

The low capacity of education in these regions is a two-fold issue, where they have both the lowest number of education facilities (an estimated 237 and 87 government schools, private schools and madrassas respectively) **as well as some of the lowest student to teacher ratios as reported by the NSIA.** For example, in Kabul province (Capital region) the NSIA projects that government primary schools have on average 38 teachers, while this number falls to 8 in Daykundi (Central Highland region) and only 4 in Zabul. These figures suggest that low educational capacity in these regions is attributed to both a low number of facilities and a limited pool of teaching staff.

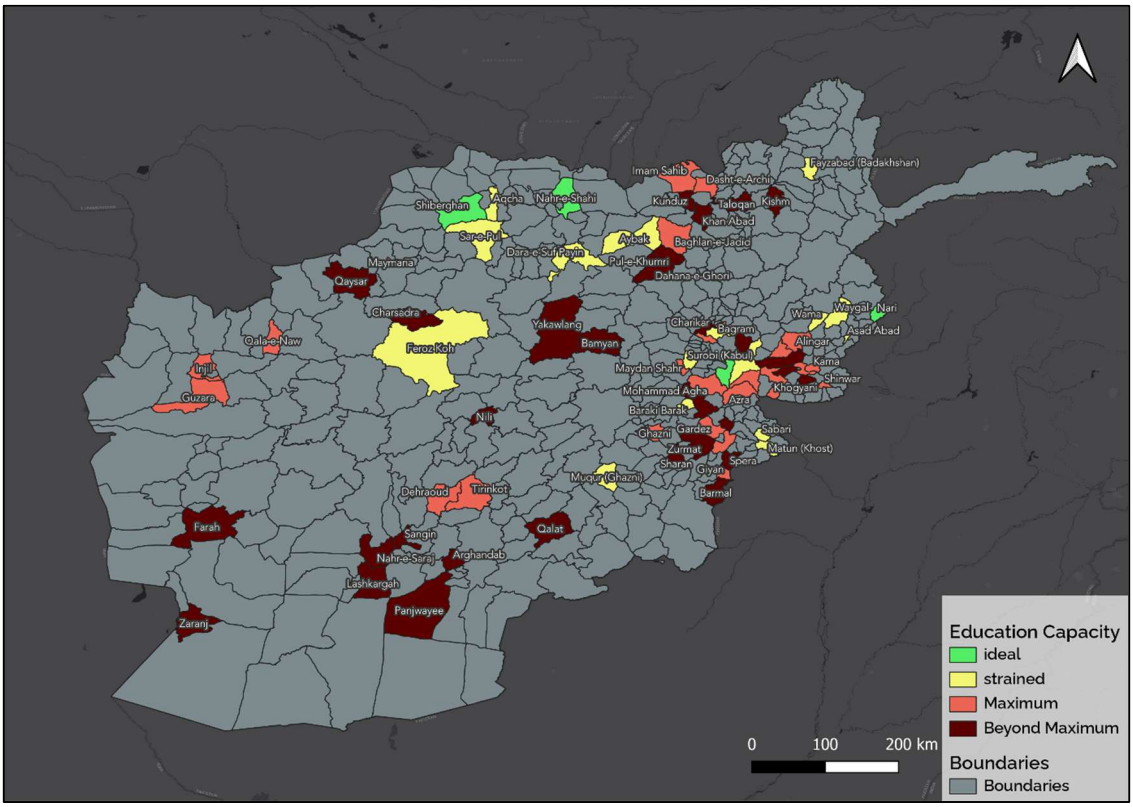
Figure 2: Primary operating capacity at a regional level (based on PARR districts)



[7] *OCHA, 'Afghanistan – Subnational Population Statistics', 2021.*

At a district level, the map below highlights that across most districts primary education capacity is severely strained, with the PARR districts in the Southern region exhibiting equally low capacity. Similarly to health capacity, **the number of IDPs and returnees is statistically insignificant in determining infrastructure strain when location is taken into account**, with being in the Southern or Central Highland provinces a significant predictor of low educational capacity.

Figure 2 Primary education capacity across the different PARR districts



Similarly to health interventions, interventions in education should be geographically targeted, the table in Annex 1estimates the number of teachers required within each PARR district to reach different operational capacity thresholds, while the table below illustrates the need for each district within a region to reach ideal capacity, strained or maximum capacity.

Table 2: Teachers needed to reach different threshold levels

Region	Primary aged population	Teachers needed to reach ideal capacity	Teachers needed to reach strained capacity	Teachers needed to reach maximum capacity
Capital	275,608	6,181	1,842	358
Central Highland	50,023	1,716	757	236
Eastern	325,430	8,826	2,868	256
North Eastern	427,997	13,190	5,204	1,144
Northern	222,882	2,873	555	29
South Eastern	209,817	4,662	1,285	357
Southern	255,457	8,977	4,080	1,527
Western	217,575	5,374	1,563	480
Grand Total	**1,984,789**	**52,061**	**18,417**	**4,651**

It is estimated that in excess of 52,000 new teachers would be required to reach ideal primary education service capacities across the PARR districts (a student ratio of 25:1 for the current school aged population), however, only 4,651 more would be required to reach maximum service capacity. The highest needs are presented in the North Eastern region (due to its large population), while PARR districts in the **Southern region exhibit the second highest need due to both a relatively high population and lack of education infrastructure** (1,527 extra teachers are required in this location to meet maximum operating capacity).

Community Based Education centres offering some relief

Photo 2: CBE in Jazwan Province (Samuel Hall)

While the availability of public, private, and religious primary schools falls short of meeting the needs of the current school-aged population, Community-Based Education Centres (CBEs) offer some relief. CBEs, informal schools primarily serving populations in hard-to-reach areas, are typically NGO-administered and open to both boys and girls. However, a recent Samuel Hall study with UNICEF revealed that increasingly restrictive regulations from the Department for Education (DfA) have rendered such services unavailable in provinces like Kandahar and Helmand.

CBEs are linked to government schools, enabling children to transition to formal education after completing the maximum grade offered at the CBE (typically grade 3). By the end of 2021, UNICEF reported 7,604 active CBEs, with 238,123 enrolled students (124,554 girls and 113,569 boys).[8] Despite this network, CBEs alone cannot address the broader gaps in education infrastructure across PARR districts.

Access

Acknowledging that availability of services is only one component of access, other sources such as the REACH SEVA 2024 data collection exercise[9], a Samuel Hall study on gendered access to healthcare and education provide greater detail into the accessibility and quality of basic services in PARR areas.

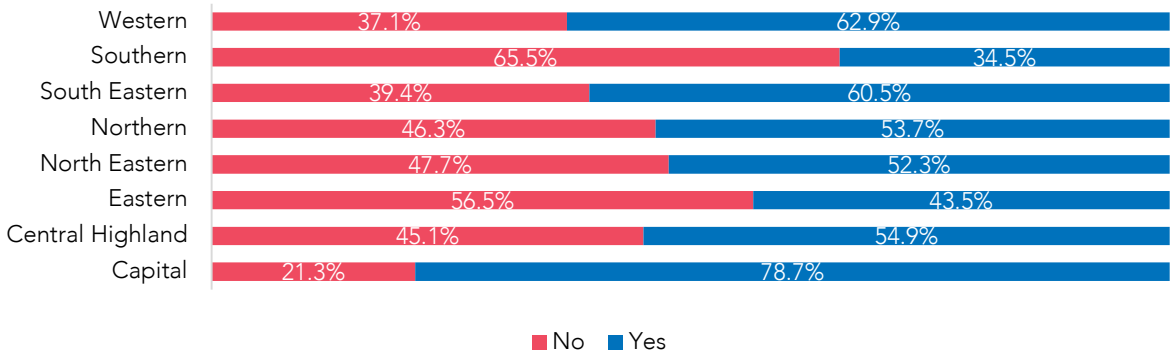
According to REACH SEVA data, there are significant variations in enrolment across the PARR districts, with respondents in the Southern region 44 percentage points less likely to have one child enrolled in education compared to households in PARR districts in the Capital region. **This finding reflects the analysis from the capacity assessment, where the Southern region was found to be the most**

[8] *UNICEF, 'Country Office Annual Report', 2021.*

[9] *This dataset contains information on education and health access across 10,070 households in 75 PARR locations.*

underserved in terms of both facilities and teachers. In Agrandabe, 99% of households reportedly did not have any children in school. In this district, there are reportedly 2 government schools and 1 madrassa, contributing to an expected maximum capacity of 1,758 students for an estimated primary school aged population of 16,024 students, exhibiting severe capacity strain.

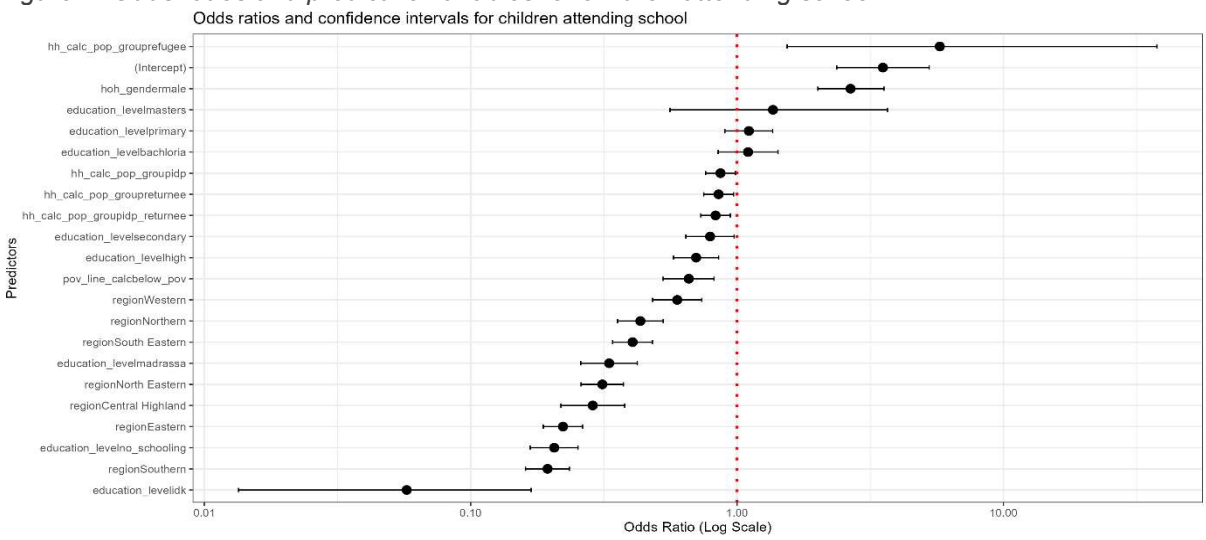
Figure 6: At least one child in the household is attending an educational facility.



Enrolment

Several factors beyond location were found to be significant when assessing school enrolment. **Both returnees and IDPs were 14% less likely than host community members to have at least one child in school**, while male headed households were 166% more likely to have a child enrolled in school than female headed households. **Education level of the household and economic status also played an important role**, with households deemed to be below the poverty line 35% less likely to have a child in school than those above the poverty line and households in which no members had received any schooling were 79% less likely to have a child in school than in household with a member who has attained a bachelor's degree. **These findings reflect that access to education is impeded by a variety of compounding factors such as displacement, economic circumstances and general education level of the household – as well as a general lack of services available.**

Figure 7: Odds ratios and predictive variables for children attending school[10]



[10] *This graph depicts the significant variables impacting enrolment in education. The point represents the odds ratio, while the line demarks the confidence interval. If the odds ratio is more than one it represents that the variable is positively associated with education enrolment, if less than*

By far the most common type of schools attended by all displacement types are government-run primary schools. 57% of respondents across all regions reported that they had a child enrolled in a public primary school, while 23% reported that they had a child attending a government administered high school. Respondents in PARR districts in the Northern and Southern regions were the most likely to report that their children were enrolled in madrassas at 22% and 15% respectively. Only 2% of respondents in the entire sample responded that their children were enrolled in NGO run CBEs (highest in the Capital and Eastern regions at 4% respectively). The vast majority of households with children attending school reported that their child attended regularly (over 95% of households), regardless of location – **suggesting that access impediments are more likely to stop a child attending education in the first place rather than attending regularly once enrolled.**

Reasons for not attending differed both across locations and across genders. Boys were 19 percentage points more likely than girls to not be enrolled due to involvement in economic activities (the reason for non-enrolment for 39% of boys in the Northern district). **Economic barriers** were further emphasised by a recent Samuel Hall study on education, with many families reportedly unable to enrol their children due to financial constraints: *'Many children are doing heavy work. Some as young as eight- or ten-years old drive tractors, collect wood and branches from the mountains, care for animals, or work hard in the fields on farms. (Case Study, Female, Kunar).* Further, as highlighted by the most recent findings from the Post Return Monitoring Report (2024 round), returnee families are hindered by a lack of access to identity documents.

24% of girls reportedly were unable to attend education due to bans and restrictions on education. Girls in the Eastern and Capital regions were most likely to be impacted as reported by 42% and 39% of households in these regions respectively: '*However, the only issue that everyone faces is the restriction on girls' education beyond the sixth grade. This is a very big and serious problem. (Case Study, Female, Laghman)*

Distance is also a substantial barrier, particularly in the Southern Region where 58% of girls were unable to attend school for this reason. Samuel Hall data reflects that distance is a compounding issue, raising both logistical and security concerns for girls looking to attend school: '*For example, in one of our classes, three students were absent, so we spoke with their parents. We asked if there was any mistreatment that could be causing their daughters to not attend class. They responded that they were not sending their children to class because the local class is far from their home, and they are concerned for their safety in case of any incidents along the way, as the distance is quite long. (KII, Male Education Officer, Kapisa)*

Poor quality schools were another impediment, and the reason that 23% of boys and 21% of girls missed school respectively. Quality impacting access were most keenly felt across the Central Highlands and South Eastern regions, where 51% of boys in the central highlands were reportedly

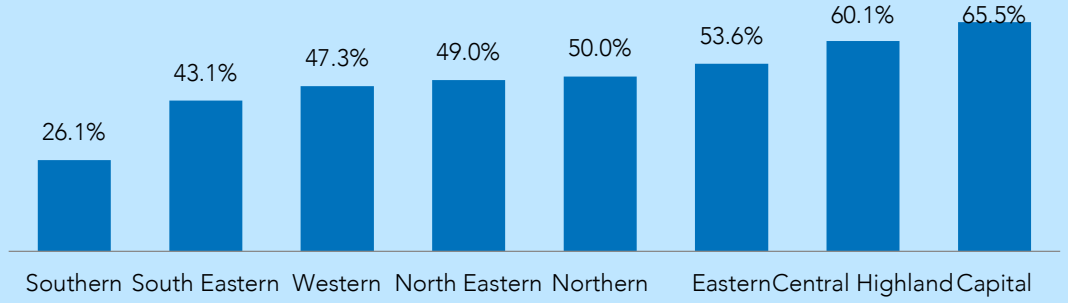
one it reflects that the variable is negatively associated with education enrolment. The further left or right the odds ratio, the higher the magnitude of the effect. If the confidence interval overlaps 1, the predictor does not have a significant relationship with enrolment. A wider confidence interval reflects a more uncertain relationship (primarily due to small sample size). The reference groups are as follows - Region: Capital, Displacement: Host, Education: Bachelors degree, Poverty line: above, HoH Gender: Female.

unenrolled due to their poor quality (35% of girls in the same location**). Limited school capacity**, highlighting what has been found throughout this analysis, is a primary quality impediment as highlighted by a participant for a 2024 Samuel Hall study in Kunar: *'from every family we have one member in our school we can't enrol more than one member from each family because we don't have space for the students. (CS, Mother, Kunduz)'*

MICS Afghanistan 2022-2023 findings[11]

MICS UNICEF data from 2022 to 2023 adds further nuance to the REACH 2024 SEVA findings. In this study, 20,022 children aged 5-17 in all provinces were asked about their enrolment status, with children in the Capital region most likely to have ever been enrolled and children in the Southern province least likely to have ever been enrolled.

Figure 8: Children aged 5-17 reporting that they have ever been enrolled in education according to MICS 2022-2023 data (weighted proportions)



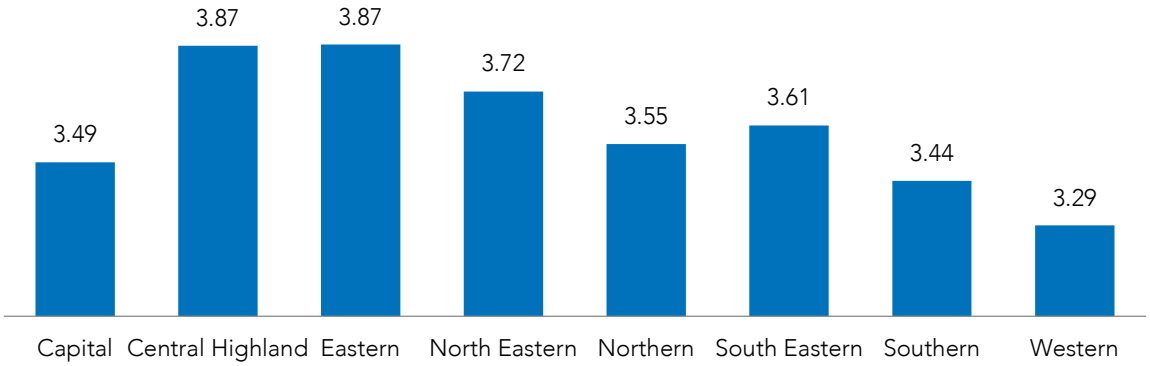
Looking at current enrolment (2022-23), it was found that many factors were correlated with positive and negative enrolment when controlling for province and region. Locality was found to a relevant factor, **with children in rural localities 9% less likely to be enrolled than in urban locations**. **Age was also a predictive factor**, with children aged 15 through 17 61% less likely to be currently enrolled than children aged 10 through 14 when controlling for gender, suggesting a high drop off in enrolment over time regardless of gender. Further, **for every additional child in household, there was a 5% decrease in the likelihood of a child currently being enrolled**, potentially reflecting the financial considerations of sending multiple children to school. Last, MICS data highlighted the importance of economic circumstances in educational attainment, with children in households categorised in the richest wealth quintile almost five times more likely to be currently enrolled than children in households in the lowest wealth quintile.

[11] *The MICS data was held across all 34 provinces but is not disaggregated at a district level. Therefore, these figures speak to all districts in the region and not just PARR districts and should be taken as indicative.*

Quality

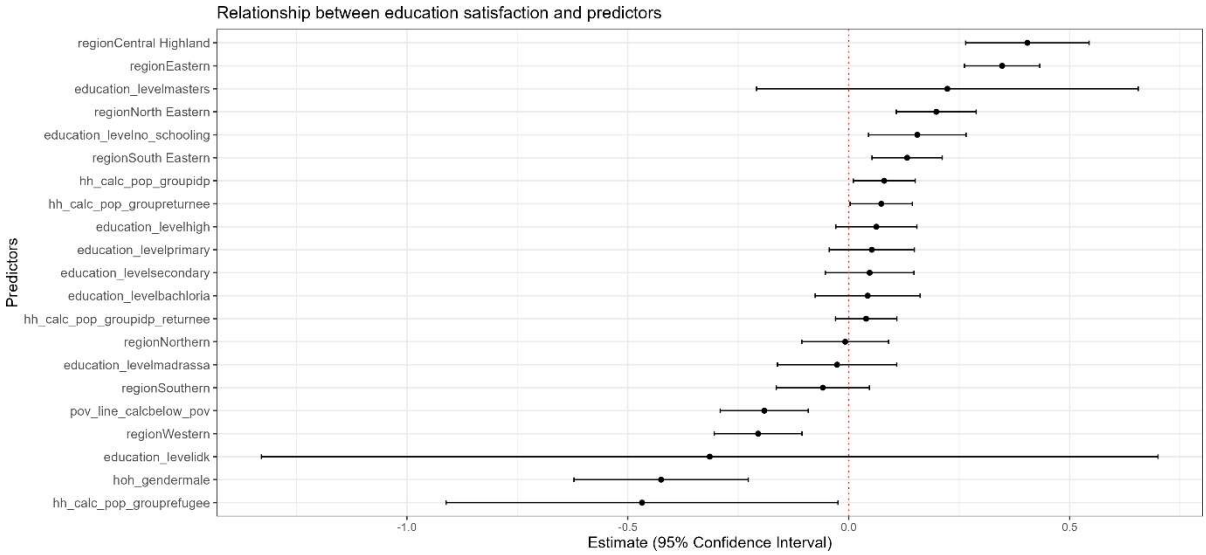
Regardless of these concerns, respondents across the regions generally reflected fairly positively about the quality of education available to them, with households across all regions rating at their satisfaction with education services as at least 3 out of a possible 5.

Figure 9: Households in PARR areas satisfaction with local health services (scaled from 0 to 5)



Satisfaction with education is significantly linked to a range of factors outside of location. **Returnees and IDP households reflected more positively upon education than host community households**. On the other hand, households below the poverty line tended to be less satisfied with education quality as well as households where the head is male. Last, household in which no members had received education were more likely to perceive the education positively compared to households with at least some level of education.

Figure 10: Relationship between education satisfaction and predictive variables[12]



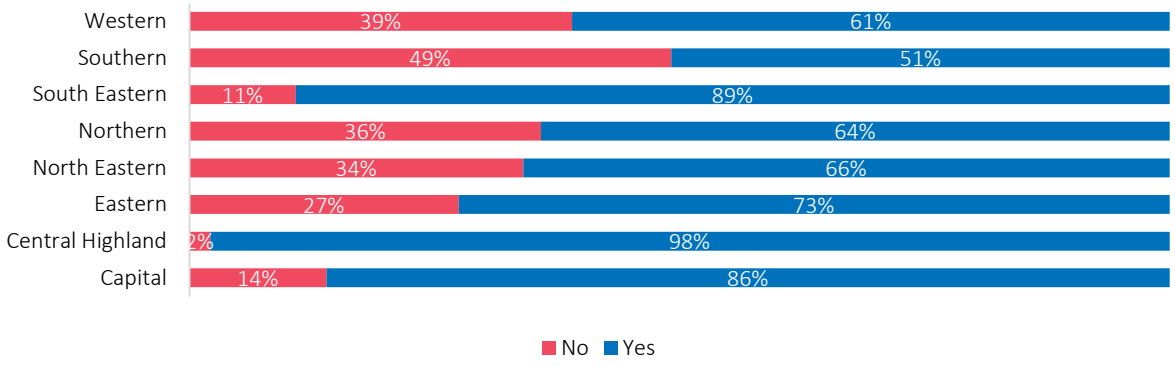
[12] *The plot visualizes the estimated coefficients from the linear regression model between education satisfaction and several potential predictor variables, along with their 95% confidence intervals. Each dot represents the estimated effect (or coefficient) of a variable on education satisfaction, while the horizontal error bars indicate the range of the 95% confidence interval. A coefficient located on the right side of the dotted line represents a positive effect on education satisfaction, while a dot on the left side of the red dotted line represents a negative effect on education satisfaction. If a confidence interval for a coefficient crosses this line, it suggests the effect is not statistically significant at the 95% confidence level. The reference groups are as follows - Region: Capital, Displacement: Host, Education: Bachelors degree, Poverty line: above, HoH Gender: Female.*

Household infrastructure and utilities

Shelter and water

According to the REACH 2024 PARR exercise, mud huts are by far the most common shelter types, used by over 80% of households, regardless of location or displacement status. Access to sufficient water is a significant constraint for many households, for which only 72% reportedly have enough water to fulfil their daily needs (cooking, washing, drinking, etc.). Deficits are most common in the Southern and Western regions where 49% and 39% of households respectively report insufficient water access.

Figure 11: Proportion of households reporting sufficient water access for daily requirements



While the size of the household and displacement status are not linked to having sufficient water, **educational attainment, economic profile and presence of a family member with a disability are significant predictors, highlighting that adequate access to water is likely attributable to systemic inequality**. Indeed, households below the poverty line are 47% less likely to report sufficient access to water when controlling for location, educational factors and household size while those with no schooling are 56% less likely to report having sufficient water access compared to households in which a member has a attained a bachelor's degree.

Handpumps, either private or public, are the most common source of water for households in the PARR districts as reported by over half of assessed households (28% of these are public sources while 24% are private). On the other hand, 20% of households reportedly had access to piped water **while alarmingly 10% of households are reliant upon unprotected spring water** (18% in the North East region, the highest amongst all assessed locations). **The water source and sufficiency are also linked,** with 90% of households who source their water from a private hand pump reporting that they had sufficient water access compared to 71% of households connected to public handpumps.

While 35% of households reported no problems with accessing water (most commonly reported in the capital region with 59% of households), the most common challenge facing households across the PARR districts is a lack of containers for fetching and storing water (36% of households and most commonly reported in the Southern region at 49% of households). Some constraints are more geographically dependent, with households in the North East region most likely to report that distance to the water source was a prohibitive factor (34% of households in this region), and households in the Southern region most likely to report that long waiting times were an obstacle.

Shelter findings from Samuel Hall Afghanistan Energy Study

In late 2023 and 2024, in collaboration with World Bank, Samuel Hall completed a study on energy access and usage across 5 provinces in Afghanistan: Daykundi, Herat, Kabul, Paktia and Samangan. 3,000 household surveys were collected of which 950 were taken in PARR districts across these 5 provinces. 25% of the surveyed households in PARR districts were returnee households

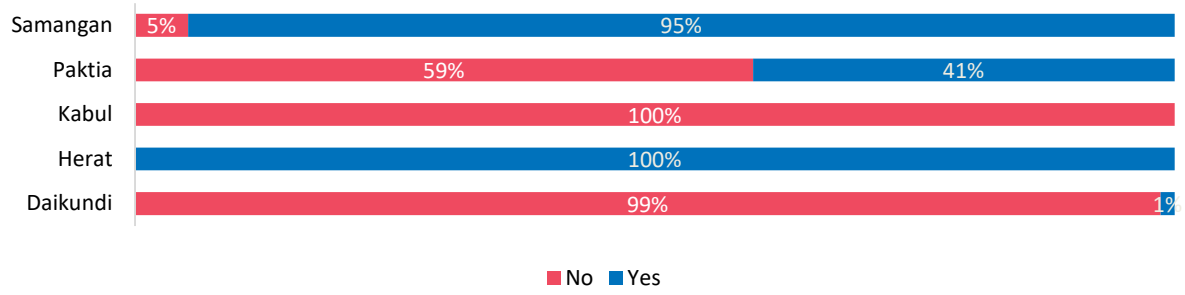
The findings from this survey match what is present in the REACH data, with a majority of shelters being mud constructions. The findings suggest that most households live in single story building occupied by one household (over 80%), with the exception being IDP households who were more likely to live in shared accommodation. The distribution between urban and rural location is the most significant factor in terms of shelter infrastructure, with stone dwellings 13 percentage points more common in urban locations than rural locations.

Photo 3: Mud dwelling in Zabul (Samuel Hall)

Electricity and heating

The Afghanistan Energy Study gives further insights into access and availability of electricity and heating. Across the 950 households assessed in PARR districts across Daykundi, Herat, Kabul, Paktia and Samangan, 39% of households were reportedly connected to the grid. Host community members were more likely to report grid access than returnees by 8 percentage points. Location was a highly relevant factor in grid access, with over 90% of households in Samangan and Herat having grid connection compared to only one percent in Daykundi. **There was also a significant divide in grid access between urban and rural households** – of the 99 households in PARR districts in Kabul, all were located in rural areas and none were grid connected

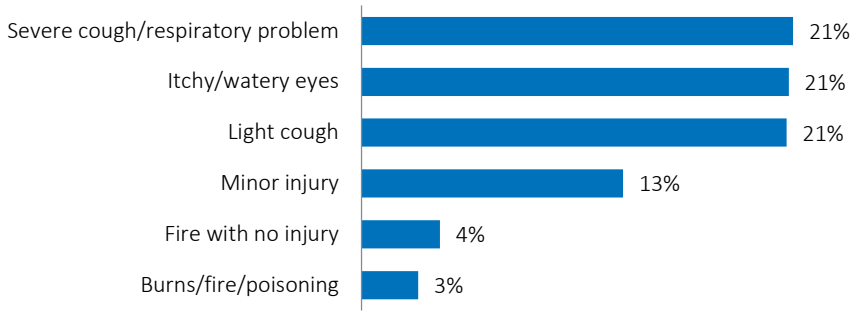
Figure 12: Proportion of households reporting sufficient water access for daily requirements



Where grid access is low, solar power becomes more widely used **– making it the most common source of electricity for households within all assessed PARR districts,** with 62% of households reporting having a solar device (72% of returnee households and 61% of host community households). According to households, solar provided at least 6 hours of electricity on average (compared to 17 hours on average reported by households with grid access) and is primarily used for lighting purposes as it struggles to power larger appliances such as fridges and heating devices.

Households in the assessed PARR districts are dependent upon wood fired Tabakhanas (45% of households), Bukhali (23% of households) and Sandali (22% of households) heating devices. Locality is a strong factor in determining which heating solutions are used, with 80% of households in rural districts relying upon Sandali's while Tabakhanas are the most common heating solution in urban areas (54% of all households). **These cooking devices are strongly linked to injuries and poor health outcomes**, with 45% of households in PARR districts reporting that using these heating devices had adverse effects on their health, particularly respiratory issues as displayed by Figure 13.

Figure 13: Illnesses and injuries caused by heating and cooking devices (SH: Afghanistan Energy Study data)



Recommendations and conclusions

This assessment highlights severe gaps in healthcare, education and water service provision across Afghanistan's PARR districts, **particularly in the North Eastern and Southern regions**. While structural limitations such as insufficient clinics, schools, and teaching staff are evident, additional factors like accessibility, gender disparities, and regulatory barriers further constrain service delivery. In healthcare, expanding clinic and hospital infrastructure is critical to addressing the acute strain in underserved districts. Investments in operational capacity, including medicine stocks, female medical staff, and transportation systems, are equally vital to ensure that existing facilities provide meaningful access. In education, expanding the teaching workforce and school facilities will significantly improve capacity. However, addressing economic, geographic, and gender-specific barriers is necessary to ensure equitable access for all children.

Infrastructure expansion to strengthen healthcare provision:

- Priority interventions should focus on the North Eastern and Southern regions, where the number of PARR districts operating beyond maximum capacity is highest. Immediate investments should aim to establish 154 additional clinics in the North Eastern region and 79 in the Southern region to meet ideal capacity thresholds.
- Targeted support is needed in underserved areas. Efforts should address the extremely limited availability of health facilities in Sukh Rhod (Nangarhar) and Barmal (Paktika), where nearly 400,000 people lack access to local healthcare services. Mobile clinics and temporary health posts can provide interim relief while permanent infrastructure is developed.

Augmenting education capacity:

- Ideally, 52,061 additional teachers would need to be recruited across all PARRs to meet ideal student-to-teacher ratios of 25:1, prioritizing the North Eastern (13,190 teachers) and Southern (8,977 teachers) regions.
- CBE programs should be expanded in hard-to-reach areas, particularly in provinces like Kandahar and Helmand where these programs have been curtailed.

Addressing access and quality barriers:

- Investments in transportation infrastructure and supply chain management are critical, particularly in remote areas like Nimroz and Kapisa. Policies should also address gender-specific barriers, including the need for female medical staff and mahram requirements for women.
- Gender and economic disparities should be tackled in school enrollment by providing targeted financial assistance to low-income families and improving the safety and proximity of schools for girls in the Southern region.

Support water provision

- As highlighted by the data, access to sufficient water sources is likely linked to structural inequalities, with households below the poverty line 47% less likely than households above the poverty line to report adequate access (when factoring for location, education level and the

gender of the head of the household). Increasing access to water for families in financial strain through either shared or private sources would be an important intervention.

Data and Monitoring

Real-time monitoring systems should track service delivery in healthcare and education across PARR districts. This should include tools to monitor attendance, staffing levels, and operational capacity to ensure efficient resource allocation. Given the important shifts in population, it would be important to monitor regularly to evaluate progress against capacity thresholds and adjust programming accordingly. Further, case studies could be held in the 4 districts which met ideal standards for education capacity to understand how they manage demand compared to other districts operating at lower capacities. Last, any further studies dedicated to education and enrollment should also consider the school in which the child is enrolled. A previous Samuel Hall study with UNICEF found that enrollment figures in Afghanistan can be misleading due to children being enrolled in the wrong grade for their age group, because of limited school infrastructure. As such, actual enrollment figures can be overexaggerated due to this mismatch.

While the suggested analytical steps above can provide an evidence-based roadmap for action, it is crucial to acknowledge that the responsibility for addressing these gaps cannot rest solely on UNHCR and its partners. Expanding and maintaining healthcare and education infrastructure is fundamentally the role of government authorities. However, the findings and numbers presented in this report are intended to guide planning, advocacy, and coordination efforts among all stakeholders, including development partners, government actors, and humanitarian organizations. By leveraging this data, stakeholders can align priorities and optimize resource allocation to foster sustainable reintegration and community resilience.

Annexes

Annex 1: Clinics and teachers needed by PARR district to reach ideal, strained or maximum capacity operating levels for health and education

Location			Population			Healthcare Capacity				Primary education Capacity			
Region	Province	District	Total population	IDP proportion of population	Returnee proportion of population	Current Healthcare Capacity	Clinics needed to reach ideal capacity	Clinics needed to reach strained capacity	Clinics needed to reach maximum capacity	Primary Education Capacity	Teachers needed to reach ideal capacity	Teachers needed to reach strained capacity	Teachers needed to reach maximum capacity
Capital	Kabul	Paghman	201,038	1%	29%	Ideal	0	0	0	Strained	52	0	0
	Kabul	Khak-e-Jabbar	27,801	0%	41%	Ideal	0	0	0	Ideal	0	0	0
	Kabul	Qara Bagh	195,392	0%	55%	Strained	5	0	0	Maximum	759	211	0
	Kabul	Surobi	113,464	8%	36%	Ideal	0	0	0	Strained	146	0	0
	Kapisa	Mahmood-e-Raqi	96,598	12%	11%	Ideal	0	0	0	Maximum	332	61	0
	Kapisa	Tagab	125,868	13%	13%	Ideal	0	0	0	Beyond maximum	646	293	101

	Parwan	Charikar	320,955	22%	14%	Ideal	0	0	0	Beyond maximum	1514	615	126
	Parwan	Bagram	212,395	5%	39%	Ideal	0	0	0	Strained	581	0	0
	Maidan Wardak	Maydan Shahr	103,451	42%	13%	Ideal	0	0	0	Maximum	426	136	0
	Logar	Pul-e-Alam	194,169	16%	21%	Ideal	0	0	0	Beyond maximum	970	426	131
	Logar	Baraki Barak	118,820	3%	12%	Ideal	0	0	0	Strained	163	0	0
	Logar	Mohammad Agha	145,079	3%	37%	Ideal	0	0	0	Maximum	492	86	0
	Logar	Azra	30,878	0%	24%	Strained	1	0	0	Maximum	100	13	0
Central Highland	Bamyan	Bamyan	163,709	36%	5%	Ideal	0	0	0	Beyond maximum	853	394	145
	Bamyan	Yakawlang	112,367	31%	7%	Ideal	0	0	0	Beyond maximum	562	247	76
	Daykundi	Nili	66,209	32%	2%	Ideal	0	0	0	Beyond maximum	302	116	15
Eastern	Nangarhar	Behsud	279,761	27%	26%	Ideal	0	0	0	Maximum	1186	403	0

	Nangarhar	Surkh Rod	323,924	16%	41%	Beyond maximum	32	9	6	Beyond maximum	1475	567	74
	Nangarhar	Kama	165,417	4%	42%	Strained	10	0	0	Maximum	705	241	0
	Nangarhar	Rodat	169,786	12%	41%	Ideal	0	0	0	Beyond maximum	742	266	8
	Nangarhar	Khogyani	301,356	26%	24%	Beyond maximum	20	4	1	Maximum	1288	443	0
	Nangarhar	Shinwar	129,184	27%	20%	Strained	8	0	0	Maximum	487	125	0
	Nangarhar	Hesarak	69,178	5%	43%	Ideal	0	0	0	Maximum	197	3	0
	Laghman	Mehtarlam	235,396	21%	15%	Ideal	0	0	0	Maximum	1000	340	0
	Laghman	Qarghayi	195,711	1%	41%	Strained	3	0	0	Beyond maximum	1021	472	174
	Laghman	Alingar	153,431	9%	19%	Ideal	0	0	0	Maximum	435	5	0
	Kunar	Asad Abad	110,599	43%	22%	Strained	7	0	0	Strained	185	0	0
	Kunar	Nari	47,140	21%	12%	Ideal	0	0	0	Ideal	0	0	0
	Nuristan	Waygal	29,386	23%	0%	Ideal	0	0	0	Strained	70	0	0

	Nuristan	Wama	16,166	21%	1%	Ideal	0	0	0	Strained	35	0	0
North Eastern	Baghlan	Pul-e-Khumri	482,591	28%	21%	Strained	9	0	0	Beyond maximum	2611	1259	525
	Baghlan	Dahana-e-Ghori	89,111	7%	17%	Beyond maximum	9	3	2	Beyond maximum	446	197	61
	Baghlan	Baghlan-e-Jadid	242,413	10%	7%	Beyond maximum	21	4	2	Maximum	965	285	0
	Badakhshan	Fayzabad	130,798	38%	2%	Ideal	0	0	0	Strained	149	0	0
	Badakhshan	Keshem	103,958	5%	5%	Ideal	0	0	0	Beyond maximum	515	223	65
	Takhar	Taloqan	410,584	29%	7%	Strained	14	0	0	Beyond maximum	1859	709	84
	Kunduz	Kunduz	746,004	40%	9%	Beyond maximum	59	10	4	Beyond maximum	3475	1385	250
	Kunduz	Khan Abad	232,673	7%	24%	Maximum	13	2	0	Beyond maximum	1166	514	160
	Kunduz	Imam Sahib	321,205	11%	16%	Beyond maximum	22	4	1	Maximum	1340	440	0
	Kunduz	Dasht-e-Archi	169,176	7%	35%	Strained	7	0	0	Maximum	665	191	0

Northern	Samangan	Aybak	162,680	20%	5%	Strained	3	0	0	Strained	409	0	0
	Samangan	Dara-e-Suf-e-Payin	127,467	32%	4%	Ideal	0	0	0	Strained	132	0	0
	Balkh	Nahr-e-Shahi	100,851	46%	3%	Strained	4	0	0	Ideal	0	0	0
	Sar-e-Pul	Sar-e-Pul	272,141	26%	8%	Strained	5	0	0	Strained	325	0	0
	Jawzjan	Shibergan	304,777	19%	16%	Ideal	0	0	0	Ideal	0	0	0
	Jawzjan	Aqcha	125,483	4%	26%	Ideal	0	0	0	Strained	243	0	0
	Faryab	Maymana	226,954	50%	6%	Ideal	0	0	0	Maximum	850	214	0
	Faryab	Qaysar	204,634	15%	5%	Beyond maximum	16	2	0	Beyond maximum	914	341	29
South Eastern	Ghazni	Ghazni	330,314	33%	10%	Ideal	0	0	0	Maximum	989	63	0
	Ghazni	Muqur	132,429	20%	37%	Strained	3	0	0	Strained	229	0	0
	Paktika	Sharan	76,800	10%	4%	Strained	4	0	0	Beyond maximum	405	190	73

	Paktika	Barmal	80,574	3%	0%	Beyond maximum	8	2	2	Beyond maximum	471	245	123
	Paktika	Giyan	48,765	0%	0%	Maximum	4	0	0	Maximum	191	55	0
	Paktya	Gardez	173,424	14%	30%	Ideal	0	0	0	Maximum	631	145	0
	Paktya	Zurmat	113,393	1%	11%	Beyond maximum	11	3	2	Beyond maximum	584	267	94
	Paktya	Zadran	30,499	4%	5%	Strained	0	0	0	Maximum	127	42	0
	Paktya	Sayed Karam	109,713	2%	19%	Maximum	8	0	0	Beyond maximum	540	232	65
	Khost	Matun	220,257	14%	13%	Ideal	0	0	0	Strained	119	0	0
	Khost	Sabari	90,118	2%	7%	Ideal	0	0	0	Strained	248	0	0
	Khost	Spera	29,189	0%	4%	Ideal	0	0	0	Beyond maximum	128	46	2
Southern	Uruzgan	Tirinkot	228,445	46%	3%	Maximum	13	2	0	Maximum	939	299	0
	Uruzgan	Dehrawud	86,976	18%	1%	Ideal	0	0	0	Maximum	318	74	0
	Zabul	Qalat	118,414	54%	7%	Strained	7	0	0	Beyond maximum	630	298	118
	Kandahar	Arghandab	109,570	26%	9%	Beyond maximum	9	1	0	Beyond maximum	622	315	148

	Kandahar	Panjwayi	181,556	34%	11%	Beyond maximum	16	3	2	Beyond maximum	1007	498	222
	Helmand	Lashkargah	527,564	52%	10%	Beyond maximum	33	5	1	Beyond maximum	2782	1305	501
	Helmand	Nahr-e-Saraj	240,309	23%	3%	Ideal	0	0	0	Beyond maximum	1325	652	286
	Helmand	Sangin	111,851	29%	1%	Strained	1	0	0	Beyond maximum	630	317	146
	Nimroz	Zaranj	143,207	11%	16%	Ideal	0	0	0	Beyond maximum	723	322	104
Western	Ghor	Feroz Koh	150,094	7%	3%	Strained	2	0	0	Strained	62	0	0
	Ghor	Charsadra	83,842	62%	0%	Ideal	0	0	0	Beyond maximum	403	168	40
	Badghis	Qala-e-Naw	166,199	52%	2%	Strained	12	0	0	Maximum	630	165	0
	Herat	Injil	543,515	41%	7%	Strained	25	0	0	Maximum	1546	24	0
	Herat	Guzara	222,562	18%	6%	Strained	2	0	0	Maximum	898	275	0
	Farah	Farah	322,564	44%	15%	Beyond maximum	32	9	6	Beyond maximum	1835	931	440

PARR INFRASTRUCTURE AND BASIC SERVICES REPORT:

2025

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