

Public Health Situation Analysis (PHSA)

This is the third PHSA published by WHO on Afghanistan.

Typologies of emergency	Main health threats	WHO grade	UNDSS Security level ¹	INFORM Risk Index (2025) ²
 Conflict	Trauma, Injury and Rehabilitation Malnutrition	P3	Across Afghanistan, the security risks are graded below: Crime: High Armed Conflict: Substantial Terrorism: High Civil Unrest: Low Hazards: Substantial	Risk Ranking: 7.8/ 10 <i>(Very High)</i> Global Risk Ranking: 7 out of 191 countries
 Food security	Diarrheal Disease			
 Displacement	Measles			
 Epidemics	Malaria			
 Earthquake	Acute Respiratory Infections (ARI)			
 Floods	Maternal and Reproductive Health Conditions			
	Tuberculosis (TB)			
	Human immunodeficiency virus (HIV)			
	Noncommunicable diseases (NCDs)			

Summary of Crisis and Key Findings

Afghanistan faces a harsh winter at a moment of heightened vulnerability and escalating humanitarian need. After multiple years of compounding shocks, families have exhausted nearly every option they once relied on to survive.³

Afghanistan is seeing an escalation of insecurity on its borders— increased fighting on the eastern and southern frontier with Pakistan, and ongoing violence in Iran.⁴ Since 26 February, violence has escalated across the Durand Line, triggering displacement of approximately 20 000 families across the Eastern, Southeastern and Southern regions.⁵ Between 26 February to 2 March 2026, there were at least 146 civilian casualties in Afghanistan, with 42 people killed, and 104 injured, including women and children.⁶ On the other side of the country, on Afghanistan’s western border, violence in Iran is sparking fears of a surge in returnees.⁷

In 2026, 17.4 million people—over one-third of the population—are facing crisis or emergency levels of hunger. A sharp increase of three million people from last year marks one of the most severe lean seasons in decades. Acute malnutrition is also worsening, impacting an estimated 3.7 million children under five and 1.2 million pregnant and breastfeeding women in 2026.⁸

Health outcomes in Afghanistan have long been shaped by profound structural disadvantage, including decades of conflict, poverty, limited infrastructure, chronic underinvestment, corruption, and aid dependence. Recent political changes have intensified these challenges, imposing new barriers that

severely limit women’s and girls’ access to health systems and their capacity to make autonomous decisions about their bodies and their health.⁹

These policies exacerbate a crisis brought on by massive cuts to international assistance that are severely undermining life-saving programs and straining an already overstretched health system. For women and girls, the cuts are converting an oppressive framework into a health catastrophe, leaving millions without essential care.¹⁰

Outbreaks of communicable diseases, maternal and child health issues, malnutrition, and non-communicable diseases contribute significantly to mortality and morbidity rates.¹¹ Trauma cases remain prevalent due to explosive ordinance contamination, sporadic explosions, and road traffic accidents. Additionally, the country is regularly affected by natural disasters such as earthquakes, drought, floods and cold waves. Psychosocial distress affects half the population, with one in five individuals experiencing impaired daily functioning due to traumatic events.¹²

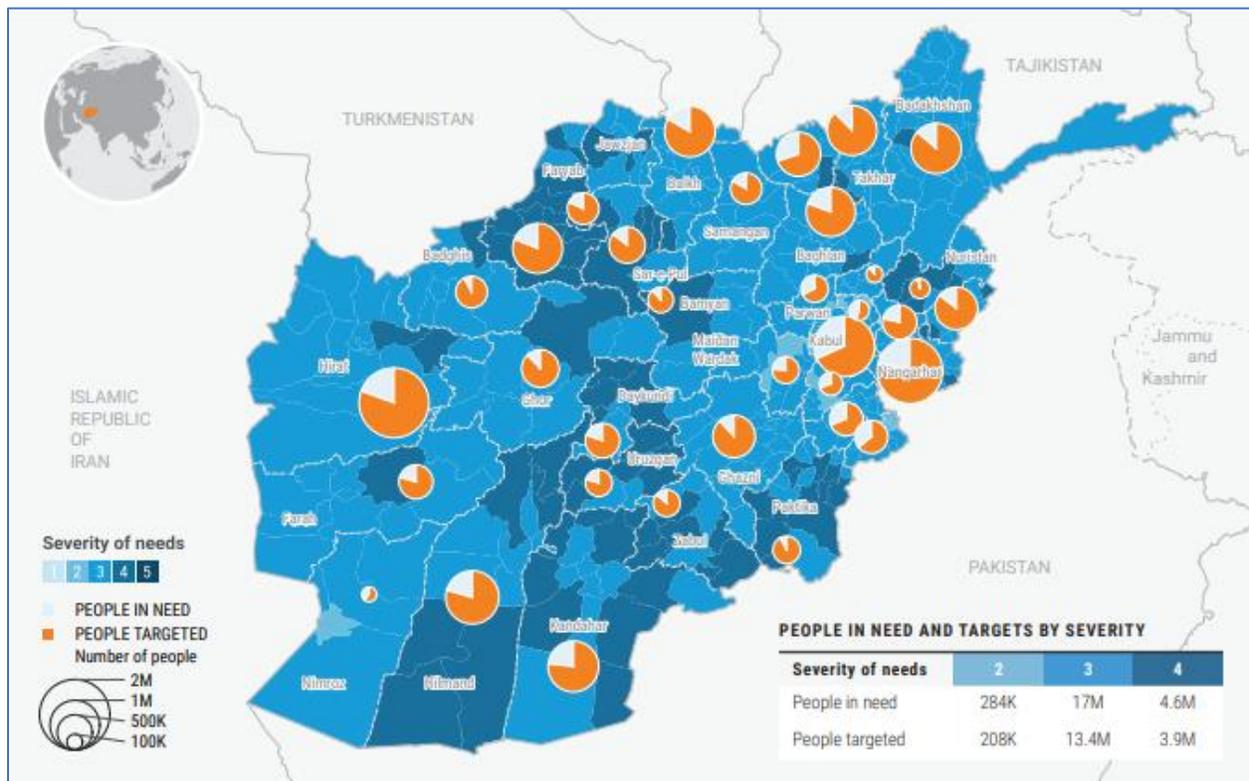
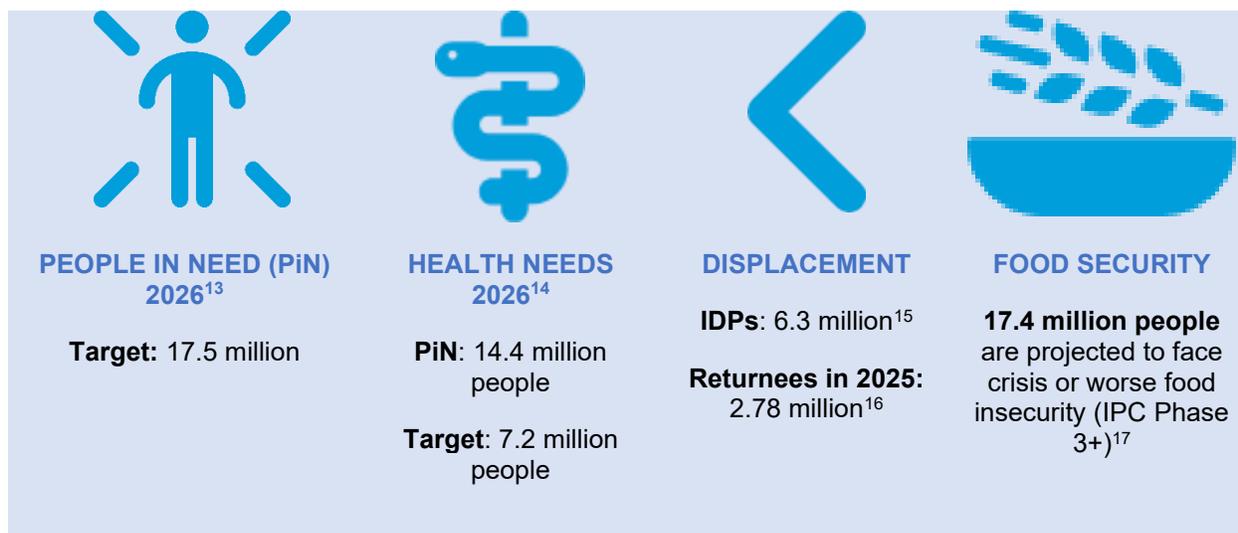


Figure 1 People In Need and Targeted by Health Cluster, 2026 (HRP)

Humanitarian Profile



Humanitarian Response in 2026

Afghanistan remains one of the world's largest humanitarian crises, with nearly half of the population –21.9 million people – projected to require humanitarian assistance in 2026.¹⁸ Only Sudan and Yemen exceed Afghanistan in scale.¹⁹

The 2026 HNRP targets 17.5 million people for assistance through a US \$1.71 billion appeal and applies a severity- and shock-based prioritization model, focusing on districts and communities facing the most acute and life-threatening conditions, including drought, large-scale returns, disease outbreaks, residual earthquake impacts and natural disasters.²⁰

As Afghanistan prepares for continued returns into 2026, the situation has shifted from a temporary emergency to a protracted humanitarian and development challenge. Sustained funding coordinated action and early investment in livelihoods and essential services are crucial. Without timely and adequate support, both returnees and host communities' risk further deterioration in living conditions and deepening vulnerability.²¹

Humanitarian Response to Date

From January to December 2025, humanitarian partners reached 17.1 million people with at least one form of assistance, including 4 million individuals who benefited from three or more sectoral interventions. While this reflects significant reach, 61% (10.5 million people) received food assistance, highlighting the extent to which food assistance continues to drive overall response figures.²²

Funding shortfalls had far-reaching impacts on humanitarian operations, affecting projects and staffing and prompting partners to reprioritize assistance. As a result, hundreds of health facilities were closed, essential malnutrition services for children were limited, critical protection services for vulnerable Afghans were cut, cash programmes supporting thousands of families were suspended, and tens of water systems supporting hundreds of thousands of people were left unrepaired.²³

OCHA reported in June 2025 that the dramatic reduction in humanitarian funding has meant that approximately 420 health facilities have closed, denying three million people access to primary health care.²⁴ Furthermore, 298 nutrition sites (out of 3455) remain closed, depriving 80 000 acutely malnourished children, pregnant women, and new mothers of treatment posing a serious risk of increased mortality.²⁵

Escalation of Border Conflict

Afghanistan is seeing an escalation of insecurity on its borders— increased fighting on the eastern and southern frontier with Pakistan, and ongoing violence in Iran.²⁶ Since 26 February, violence has escalated across the Durand Line, triggering displacement of approximately 20 000 families across the Eastern, Southeastern and Southern regions.²⁷ Between 26 February to 2 March 2026, there were at least 146 civilian casualties in Afghanistan, with 42 people killed, and 104 injured, including women and children.²⁸ On the other side of the country, on Afghanistan's western border, violence in Iran is sparking fears of a surge in returnees.²⁹

The current escalation follows a period of increased clashes between the two parties since 10 October 2025 over cross-border militant activity and disputes over armed group sanctuaries. Despite a 15 October ceasefire brokered by Qatar, Saudi Arabia, and Türkiye, clashes continued throughout the remainder of 2025. Further talks on the implementation of a lasting ceasefire and the reopening of cross-border trade have failed to make progress.³⁰

Earthquakes

The earthquake in eastern Afghanistan on 31 August 2025 was one of the deadliest to ever hit the country, killing more than 2 000 people and damaging more than 8000 homes.³¹ Later, on 3 November 2025, a 6.3-magnitude earthquake struck northern Afghanistan near the Balkh and Samangan border. The earthquake killed 26 people and injured 1050. In Samangan Province, 13 people were killed and 421 injured, while Balkh Province reported 12 deaths and 635 injuries. Overall, 3898 families were verified as affected, with more than 1000 homes destroyed and nearly 3000 homes damaged, leaving thousands of people exposed as winter temperatures set in.³²

After the earthquake, as of February 2026, approximately 5675 earthquake-affected families remain displaced in six temporary camps across Kunar and Nangarhar provinces. As winter intensifies, temperatures continue to drop, and the situation is further compounded by inadequate shelter, poor WASH facilities, and limited heating- factors that significantly increase the risk of seasonal disease outbreaks among the displaced populations.³³ About 25 000 children are living in tents in Afghanistan's Kunar province with homes and schools yet to be rebuilt and no timeline for reconstruction.³⁴

The devastating earthquakes caused widespread damage to homes, cropland, food stocks, livestock assets, and critical health, nutrition and WASH infrastructure, compounding an already severe humanitarian situation. In rural areas of eastern Afghanistan, where families depend heavily on farming and livestock for both food and income, the damages and losses incurred have had lasting consequences.³⁵

The Eastern Region earthquake and subsequent aftershocks that struck eastern Afghanistan on 31 August 2025 caused an estimated US\$86.8 million in total damages and losses across ten assessed districts, comprising US\$68.7 million in damages and US\$18.1 million in losses. Geographically, the heaviest impacts were concentrated in the hardest-hit districts of Kunar province, where housing collapse rates and livelihood losses were highest. Recovery and reconstruction needs were estimated at US\$128.8 million over three years, with US\$59 million required in the first 12 months for early recovery interventions to prevent further impoverishment and protracted displacement.³⁶

More broadly, Afghanistan faces multiple natural hazards, with nearly two million people living in areas that would be heavily impacted by heavy flooding and 17 million people living near fault lines in high-risk seismic zones.³⁷ Over the past decade, more than 600 000 people have been affected by earthquakes in Afghanistan, with an average of 188 fatalities annually.³⁸

Displacement

Since 26 February, violence has escalated across the Durand Line, triggering displacement of approximately 20 000 families across the Eastern, Southeastern and Southern regions.³⁹ On the other side of the country, on Afghanistan's western border, violence in Iran is sparking fears of a surge in returnees.⁴⁰

Before the most recent escalations in conflict, Afghanistan was expected to receive a substantial influx of returnees, with projections estimating around 1.6 million individuals arriving from Iran and up to 1.2 million returnees coming from Pakistan.⁴¹ Over the past two years, roughly five million people, nearly 10% of the population, have returned, fleeing deportations and tightening migration restrictions in neighbouring countries.⁴²

In 2025 alone, an estimated 2.78 million Afghans returned, the majority from Iran (1.88 million) and Pakistan (899,000), including 2.3 million undocumented and 484 000 documented returnees. At the peak of the year, daily arrivals from Iran surged to 30 000 – 40 000 in June and July, overwhelming border reception points and putting severe strain on onward movement systems.⁴³ Policy changes, tightening documentation regimes, misinformation, disinformation, and deteriorating socio-economic and protection conditions for Afghans in neighbouring countries, particularly Iran and Pakistan, were key drivers.⁴⁴

Despite determined efforts of UN agencies and local authorities, and a powerful public outpouring of practical support to the returnees, the pace and scale of returns are overwhelming already fragile support systems. Meanwhile, humanitarian operations remain dangerously underfunded.⁴⁵ Economic pressures are compounding the crisis. The sudden influx of returnees has intensified competition for low-skilled jobs, suppressing wages and limiting income opportunities in already fragile markets. Many households face worsening food insecurity and are resorting to negative coping strategies. The return of school-aged children has also increased demand for education services, as families attempt to re-enrol children who have experienced prolonged disruptions to learning.⁴⁶

Women, girls and children face heightened risks. Nearly one-third of returnees are women and girls, while children under 17 — including unaccompanied and separated minors require urgent protection, family tracing and psychosocial support. Undocumented returnees face the greatest barriers to services, livelihoods and legal protections, leaving them highly vulnerable.⁴⁷

The returnee population also adds to the existing 6.3 million internally displaced Afghan nationals, who often reside in the same locations. This hinders communities' capacity in areas of return to integrate returnees and exacerbates overall protection situation, further hindering the access to limited resources and services.⁴⁸

Food Insecurity

During the 2025–2026 lean season (November 2025 – March 2026), 17.4 million people are projected to face crisis or worse food insecurity (IPC Phase 3+), including 4.7 million people in emergency food insecurity (IPC Phase 4). This represents a severe deterioration from the same period last year, with emergency hunger levels rising by more than 50%.⁴⁹

The worsening food crisis is primarily driven by drought, erosion of livelihoods and population pressure from large-scale returns, compounded by chronic poverty, a stagnant economy and recurrent climate-related shocks.⁵⁰

Since 26 February, cross border violence and air and ground strikes have affected more than 30 districts.⁵¹ Across these areas, WFP has been forced to temporarily suspend emergency, social protection, school feeding and livelihood activities. Approximately 160 000 people have been impacted by the suspension of emergency food distributions.⁵² The affected districts were already facing severe food insecurity, with more than half in Emergency levels of hunger, while four of the affected provinces are experiencing critical levels of acute malnutrition – leaving families in an increasingly dire situation.⁵³

Countrywide, food and income constraints are expected to be most severe during the February to April lean season. Access to food and income will most likely be the most constrained in Faryab, Ghor, and Daykundi provinces, where Emergency (IPC Phase 4) outcomes are expected to emerge in February, as households face extreme difficulty accessing food. Poor households in these provinces have no food stocks from their own production and are anticipated to be completely market reliant for food, with extremely poor purchasing power.⁵⁴

Crisis (IPC Phase 3) and Stressed (IPC Phase 2) outcomes are expected to remain widespread through May 2026 in the rest of the country as households face difficulty meeting their food and non-food needs due to the impacts of the multiyear drought, declines in remittances, and limited labour opportunities amid a high number of returnees and a stagnant economy.⁵⁵

Conditions in the southern and western regions improved over the course of December. Notably, the provinces of Daykundi, Farah, Ghor, Hilmand, Hirat, Kandahar, Nimroz, Nuristan and Uruzgan shifted from watch status to recovery and then to no drought conditions. Conditions in the rest of the country remain largely unchanged and at warning level. This improvement follows below-average precipitation received between October and November, followed by significantly improved rainfall in December. However, weather conditions continue to vary across regions, and in areas where below-average precipitation persists, including parts of the south, soil moisture stress is expected to continue.⁵⁶

Humanitarian Access

Afghanistan is seeing an escalation of insecurity on its borders— increased fighting on the eastern and southern frontier with Pakistan, and ongoing violence in Iran.⁵⁷ Restrictions on movements in the border area due to the active conflict have reduced the capacity of humanitarian agencies and partners to deliver life-saving and other assistance in the most-affected areas, leaving Afghan returnees from Pakistan particularly vulnerable.⁵⁸

In January 2026, humanitarian partners reported a total of 121 access incidents, representing a 13% increase compared to the previous month.⁵⁹ This increase reflects a worsening of humanitarian access conditions across Afghanistan, which remained constrained by interference in the implementation of humanitarian activities, significant physical access challenges related to winter conditions and incidents affecting the safety and security of humanitarian personnel and assets.⁶⁰

Humanitarian partners reported interference in recruitment and procurement processes, including pressure to hire individuals nominated by de facto line departments, accompanied by warnings that failure to comply could result in the suspension of activities or the closure of INGO offices. In addition, partners received official requests for sensitive data, including beneficiary lists.⁶¹ Restrictions on the participation of female humanitarian workers remained a challenge. In some locations, de facto authorities opposed the work of female health workers, despite their critical role in service delivery. As a result, humanitarian partners activities suspended, reducing partners' ability to operate and deliver essential services.⁶²

Violence against humanitarian personnel, assets, and facilities remained a significant access challenge during the reporting period, with seven incidents reported, representing an increase compared to the previous month, when four incidents were recorded.⁶³ Humanitarian partners reported the detention of eight humanitarian staff. Partners also reported threats against humanitarian staff linked to the security environment, increasing risks to staff safety and affecting operational presence. Overall, gender-related access constraints remained a significant challenge in January, compounding existing operational challenges.⁶⁴

The physical environment continued to pose a major access challenge during January, as severe winter conditions affected large parts of Afghanistan.⁶⁵ Heavy snowfall, icy roads, and poor road infrastructure significantly limited access to remote and hard-to-reach areas. Humanitarian partners reported a total of 49 access incidents related to physical constraints, which resulted in movement restrictions for humanitarian partners, reduced field visits and monitoring activities and, in some cases, the temporary suspension of health activities.⁶⁶

Vulnerable Groups

Health in Afghanistan has long been shaped by a complex mix of geography, socioeconomic status, conflict, political instability, traditional norms, poor infrastructure, and limited institutional capacity. These factors have never affected all Afghans equally. Indeed, health outcomes have consistently reflected deep social inequalities, including along lines of gender, socio-economic status, location, ethnicity, religion, literacy, and ability/disability.⁶⁷ A summary of the challenges facing some of the most vulnerable groups are below:

Women and girls: The de facto authorities enforced an ideological system of governance rooted in patriarchal gender stereotypes designed to strip women of their rights and agency. These restrictions are imposed through discriminatory edicts, coercive measures including physical violence, and ideological indoctrination. A highly repressive social order is being normalised, in which women's and girls' autonomy is progressively erased, with profound consequences for physical and mental health, health-seeking behaviour, and survival.⁶⁸ Young women and adolescent girls face compounded restrictions due to their age, position in the family, and expectations of obedience.⁶⁹

People with Disabilities (PwD): Decades of conflict have left an estimated 800 000 Afghans (2.7% of the population) with a range of severe disabilities. The main categories of disability are physical (37%), sensory (26%) and multiple disabilities (46%). Between 60-80% of people with disabilities live in rural and informal urban settlements.⁷⁰ Women with disabilities face discrimination, accessibility constraints, and insufficient specialized services.⁷¹

Children and Youth: At least 12 million children need humanitarian assistance. Adolescent girls in Afghanistan face a heightened risk of child marriage and gender-based violence. Additionally, limited access to skills development and employment opportunities leaves young people vulnerable to child labour and economic exploitation and often compelled to engage in hazardous work.⁷²

Older People: Accounting for 2% of the population, older adults are particularly at risk of multidimensional poverty as evidenced in Afghanistan and the loss of access to basic services.⁷³ Older women experience a pronounced form of invisibility within the health system. In the Bishnaw health survey, 46% of women over 60 reported being unable to reach a health facility when needed. Age-related health needs are often complex and extend beyond maternal or basic health services. For older women, untreated illnesses, poor nutrition, and lack of preventive or regular care accelerate physical decline, increase the risk and impact of chronic illnesses, and contribute to earlier aging and reduced life expectancy.⁷⁴

Displacement: Displacement, returnee status, and lack of personal identity documentation can prevent those in need, often women, from registering at facilities, receiving referrals, or accessing humanitarian support. Meanwhile ethnic, religious, and linguistic minority women have reported bias or discrimination within the health system.⁷⁵

Returnees to Afghanistan: Afghanistan experienced large-scale return movements in 2025, with an estimated 2.9 million Afghan returns.⁷⁶ Policy changes, tightening documentation regimes, misinformation, disinformation, and deteriorating socio-economic and protection conditions for Afghans in neighbouring countries, particularly Iran and Pakistan, were key drivers. Returns frequently involved abrupt departures, limited time to prepare, abandoned assets, family separation, inhuman detention conditions and difficult journeys back to Afghanistan, heightening protection risks on arrival and straining reception and reintegration capacities in areas of return.⁷⁷

Health Status and Threats

Population mortality

In Afghanistan, the current population is 48.6 million as of 2026 with a projected increase of 85% to 76 885 135 by 2025.⁷⁸ The top five causes of death include collective violence and legal intervention, ischaemic heart disease, preterm birth complications, stroke and lower respiratory infections.⁷⁹ Maternal and child health needs, coupled with malnutrition, contribute significantly to mortality, with Afghanistan bearing the highest global maternal and under-5 mortality rates.⁸⁰

Mortality Indicators	Afghanistan	Year	Source
Life expectancy at birth	62.88	2022	World Bank
Infant mortality rate (deaths < 1 year per 1000 births)	45	2023	IGME
Child mortality rate (deaths < 5 years per 1000 births)	58	2023	IGME
Maternal mortality ratio (per 100 000 live births)	620	2022	WHO

Vaccination coverage

This urgency for improving vaccination campaigns has been further intensified by overlapping humanitarian pressures, including the August 2025 earthquakes, which damaged health facilities and disrupted essential systems and services.⁸¹

In addition, the return of millions of people to Afghanistan, many of them children with limited or interrupted access to essential healthcare, predisposes them to vaccine preventable diseases including polio, measles, whooping cough etc. Together, these shocks increase the risk of intense poliovirus transmission at a critical moment for global polio eradication, making a continuous and predictable vaccine supply essential to protect recent gains and prevent setbacks.⁸²

Without access to vaccination services, especially in remote areas, communities face heightened risks of disease outbreaks, increased child mortality rates, and long-term health challenges. Vulnerable groups, such as children and pregnant women, are particularly impacted, resulting in preventable deaths and placing major strain on already burdened healthcare systems.⁸³

Vaccination Coverage Data	Afghanistan	Year	Source
DTP-containing vaccine, 1st dose	450 948 (90%)	Q2, 2024	DHIS2
DTP-containing vaccine, 3rd dose	389 937 (78%)	Q2, 2024	DHIS2
OPV, 3rd dose	389 149 (78%)	Q2, 2024	DHIS2
Measles-containing vaccine, 1st dose	355 636 (71%)	Q2, 2024	DHIS2

Overview of Key Disease Risks

Afghanistan: Key Health Risks in Coming Months		
Public health risk	Level of risk***	Rationale
Trauma, Injury and Rehabilitation		Trauma is a major significant public health concern in Afghanistan. Between 26 February to 2 March 2026, there were at least 146 civilian casualties in Afghanistan, with 42 people killed, and 104 injured, including women and children. ⁸⁴ These figures remain preliminary. ⁸⁵ The civilian casualties include those caused by indirect fire in cross-border clashes, which impacted residential areas in Paktya, Paktika, Nangarhar, Kunar and Khost provinces in Afghanistan, as well as those caused by airstrikes in Paktika and Nangarhar provinces. ⁸⁶
Malnutrition		The humanitarian situation is deteriorating. Humanitarian needs are at extreme levels, driven by economic collapse, harsh winter conditions, mass returns from Iran and Pakistan, and severe funding cuts. Malnutrition is now projected to hit record highs: 3.7 million children under five and 1.2 million pregnant and breastfeeding women are acutely malnourished. Since 12 October 2025, the Pakistan border closure has disrupted critical nutrition supply chains, forcing humanitarian actors to find alternative and fragile supply routes. ⁸⁷
Diarrheal Disease		In December 2025, a total of 7969 new cases and three associated deaths (CFR: 0.04%) were reported, compared to 9548 cases and four deaths in November. This represents a 16.5% decrease from the previous month and reflects a continued downward trend since August 2025, following the earlier rise observed in February 2025. ⁸⁸
Measles		A total of 2095 new measles cases with 10 associated deaths (CFR 0.5%) were reported, reflecting a 1.5% decrease compared to 2,126 cases and 11 deaths reported in November. Comparatively, there isn't significant change in the case count reported in the months of November and December. ⁸⁹
Malaria		After declining between 2018 and 2021, malaria cases began increasing again in 2022, peaking in 2024 and remaining high through 2025. ⁹⁰ Nangarhar, Laghman, Kunar and Nuristan are among the most affected provinces where nearly every household faces malaria during the peak season. Most cases are caused by <i>Plasmodium vivax</i> , a parasite that can remain in the body and cause malaria to return weeks or months later. ⁹¹
Acute Respiratory Infections (ARI)		In December, the surveillance system recorded 1833 02 cases of ARI pneumonia and 352 deaths (CFR 0.2%) indicating a 24.6% increase compared to the 147 138 cases and 248 deaths reported in November. ⁹²
Maternal and Reproductive Health Conditions		Afghanistan has one of the world's highest maternal mortality rates: a woman dies in childbirth every two hours. This crisis worsens as nearly 80% of essential health centers risk closing due to funding shortages. ⁹³ The maternal mortality ratio in Afghanistan has improved from 1 346 in 2000 to 620 in 2020. Maternal mortality in Afghanistan is higher than its regional average. ⁹⁴

Tuberculosis (TB)		TB continues to be a major public health challenge in Afghanistan. Medicines and diagnostics are made available free of charge in the country. ⁹⁵ In 2021, the estimated TB incidence in Afghanistan was 76 000, and an estimated 12 000 people died. Afghanistan reported 50 324 case notifications. ⁹⁶
Human immunodeficiency virus (HIV)		According to the latest UNAIDS estimates (2023 data, published in the 2024 Global AIDS Report), in Afghanistan, 1700 people were newly infected with HIV. ⁹⁷ Afghanistan is experiencing a low and concentrated HIV epidemic and HIV is a public health concern among the key affected and vulnerable populations. ⁹⁸
Noncommunicable diseases (NCDs)		Almost 50% of all deaths in Afghanistan are caused by NCDs, and this proportion is projected to rise by 2030. ⁹⁹ There is a double burden of communicable and non-communicable illnesses in Afghanistan, made worse by the humanitarian catastrophe that has been triggered by the country's political instability and armed conflict during the last 40 years. ¹⁰⁰
Mental Health Conditions (including substance abuse)		Afghan beliefs about mental health are influenced by collectivism, prioritizing family and community well-being over individual needs. Mental health issues are often attributed to social or familial disharmony, which may affect perceptions of family honour. Religious beliefs play a central role, with many attributing mental illnesses to supernatural forces like jinn (spirits), the evil eye, or divine punishment. Furthermore, decades of war have normalized trauma and impacted their resilience and endurance. ¹⁰¹
Crimean-Congo Haemorrhagic fever (CCHF)		CCHF is a particular regional concern because of endemicity in Afghanistan and many neighbouring countries. The prevalence of CCHF has been increasing in this region. These concerns are compounded because there is no vaccine or therapeutic for CCHF and Afghanistan lacks adequate public health infrastructure in preventing, detecting, and containing cases. ¹⁰²
Dengue Fever		Dengue fever is endemic in Afghanistan and was first detected in 2019. Since 2022, it has spread along seven border provinces in the country's eastern and south-eastern regions, threatening approximately five million people living in high-risk areas due to rapid population movements. ¹⁰³
Polio		Afghanistan is affected by ongoing endemic wild poliovirus transmission and remain one of the two endemic countries globally. Three new WPV-1 positive cases in 2025 from Afghanistan reported this week. The new WPV1-positive cases were all from Paktika province (Bermel district) with onset dates between 6 th and 10 th October 2025. In total, 47 WPV1-positive cases have been confirmed in 2025 to date (16 from Afghanistan and 31 from Pakistan in 2025). ¹⁰⁴
Protection Risks (including GBV)		Afghan women face physical and sexual violence from intimate partners at rates nearly three times higher than the global average; 34.7% reported being subject to such violence in the preceding 12 months, compared to 13% globally. ¹⁰⁵ Practices such as honour killings, forced and child marriages, and the exchange of women and girls in dispute resolutions (baad) exacerbate gender-based violence. ¹⁰⁶
Diphtheria		There is a low coverage of EPI (extended program for Immunization). According to MICS report 2022-2023, the 3rd dose of DTP vaccination coverages was 51.3% among children between 12-23 months and

		41.6% among children between 24-35 months. This resulted in many VBD outbreaks including Diphtheria outbreaks.
Skin Infections		Kabul is currently the largest focus of anthroponotic cutaneous leishmaniasis worldwide. In Afghanistan, 10 out of 34 provinces are badly affected. ¹⁰⁷ Several outbreaks of leishmaniasis and scabies occurred in 2023 and 2024. Scabies have also been reported as outbreak events from different provinces. Migration and displacement contribute to increasing numbers of new cases annually. ¹⁰⁸
Mpox		To date there are no cases reported in Afghanistan.
Meningitis		Acute bacterial meningitis (ABM) is an important cause of morbidity and mortality in children but there is little published on ABM in Afghanistan. ¹⁰⁹ There is widespread childhood malnutrition and approximately 50% of children have anaemia and vitamin A deficiency. Immunization coverage against routine childhood illnesses is very low with substantial differences between cities and rural areas. ¹¹⁰
<p>Red: Very high risk. Could result in high levels of excess mortality/morbidity in the upcoming month. Orange: High risk. Could result in considerable levels of excess mortality/morbidity in the upcoming months. Yellow: Moderate risk. Could make a minor contribution to excess mortality/morbidity in the upcoming months. Green: Low risk. Will probably not result in excess mortality/morbidity in the upcoming months.</p>		

Trauma, Injury and Rehabilitation

Trauma is a major significant public health concern in Afghanistan. Every day, at least 8 civilians die and 17 more are injured because of trauma events. In 2020 alone, over 3000 civilians died from conflict-related trauma. Children also account for many trauma victims, with blast injuries accounting for most injuries suffered by children in Afghanistan.¹¹¹

Between 26 February to 2 March 2026, there were at least 146 civilian casualties in Afghanistan, with 42 people killed, and 104 injured, including women and children.¹¹² These figures remain preliminary.¹¹³ The civilian casualties include those caused by indirect fire in cross-border clashes, which impacted residential areas in Paktya, Paktika, Nangarhar, Kunar and Khost provinces in Afghanistan, as well as those caused by airstrikes in Paktika and Nangarhar provinces.¹¹⁴

Before the escalation, in early February 2026, the UN received credible reports of civilian casualties as a result of overnight airstrikes carried out by Pakistan inside Afghanistan. Preliminary civilian casualty figures indicate at least 13 civilians were killed and seven others injured, including women and children.¹¹⁵

According to the Ministry of Public Health data, 369 Afghans lost their lives in traffic accidents while 25 654 sustained injuries because of road accidents in 2017. WHO estimates that more than 4700 Afghans die in road traffic accidents every year.¹¹⁶

Studies have highlighted major challenges in the delivery of trauma care services in Kabul, with systematic improvement in the workforce training, structural organization of the trauma care system and implementing externally validated clinical guidelines for trauma management could possibly enhance the functions of the existing trauma care services.¹¹⁷

Nearly one in four Afghans live with a disability, many requiring health and rehabilitation services. Clinics frequently lack accessibility features, adapted examination facilities, or sign language support. Essential services such as physiotherapy, assistive devices, and rehabilitation are concentrated in a few urban centres leaving rural residents and those with limited mobility particularly vulnerable.¹¹⁸

At least 6.4 million Afghans are at risk of unexploded ordnance, with children accounting for 80% of blast fatalities and injuries.¹¹⁹ Unexploded ordnance continued to cause harm to civilians, mostly children. During the first quarter of 2025, a total of 16 civilians were killed (six men, two girls and eight boys) and 35 were wounded (3 men, 1 woman, 9 girls and 22 boys).¹²⁰

Decades of conflict have left an estimated 800 000 Afghans (2.7% of the population) with a range of severe disabilities. The main categories of disability are physical (37%), sensory (26%) and multiple disabilities (46%). Between 60-80% of people with disabilities live in rural and informal urban settlements.¹²¹

ICRC estimate that 200 000 people need a corrective device in Afghanistan, with close to 10 000 new Afghans registering with the ICRC to receive limb-fitting and physical rehabilitation every year. Only 10% of them are those who've suffered war-related injuries; the remaining 90% became disabled due to a congenital condition, disease or accident.¹²²

Over the past decade, more than 600 000 people have been affected by earthquakes in Afghanistan, with an average of 188 fatalities annually.¹²³

Malnutrition

Humanitarian needs are at extreme levels, driven by economic collapse, harsh winter conditions, mass returns from Iran and Pakistan, and severe funding cuts. Malnutrition is now projected to hit record highs: 3.7 million children under five and 1.2 million pregnant and breastfeeding women are acutely malnourished. Since 12 October 2025, the Pakistan border closure has disrupted critical nutrition supply chains, forcing humanitarian actors to find alternative and fragile supply routes.¹²⁴

As of February 2026, for the first time in decades, drastic humanitarian assistance reductions mean WFP cannot respond at the level needed to protect families from extreme hunger. With the current funding, WFP can assist 2 million people per month out of 17.4 million who urgently need food assistance. WFP's current nutrition services can reach only one in four acutely malnourished children and one in three pregnant or breastfeeding women—leaving millions at heightened risk of deterioration and illness.¹²⁵

Afghanistan ranks among the top 15 countries with the highest rates of child wasting.¹²⁶ At least 3.5 million young children suffer from wasting, from which 1.4 million are at higher risk of mortality. Surprisingly, over 85% of these children are younger than 2 years of age.¹²⁷ Unfortunately, more than 2.1 million children under the age of five are in food poverty in Afghanistan, with 1.2 million trapped in severe food poverty. These children are 33% more likely to experience stunting and developmental delays. Afghanistan now ranks fourth globally in rates of severe child food poverty.¹²⁸

Malnutrition is a top cause of death in children under five, contributing to 45% of deaths among children under 5. A child with acute malnutrition is 12 times more likely to die than a well-nourished child. Also, the complicated cases of severe acute malnutrition increased significantly compared to pre-15 August 2021.¹²⁹

Chronic nutritional deficiency in Afghanistan is largely the result of the children eating the wrong types of food, in addition to not enough food. For example, only half of Afghan babies are exclusively breastfed in their first six months.¹³⁰ Only 12% of Afghan children aged 6-24 months receive the right variety of food in the quantity needed for their age.¹³¹ One in three adolescent girls suffers from anaemia.¹³² Despite impressive improvements in the past decade, Afghanistan's health system still faces a number of challenges including some cultural practices and preferences related to food.¹³³

Diarrheal Disease

In December 2025, a total of 7969 new cases and three associated deaths (CFR: 0.04%) were reported, compared to 9548 cases and four deaths in November. This represents a 16.5% decrease from the previous month and reflects a continued downward trend since August 2025, following the earlier rise observed in February 2025.¹³⁴

Since the beginning of the year, the highest cumulative incidence of AWD with dehydration per 10 000 population was reported from Kabul (110.7), followed by Paktya (93.5), Farah (88.3), Nimroz (71.6), and Paktika (57.5) (. Also, 12 460 Rapid Diagnostic Tests (RDT) have been conducted on AWD with dehydration cases, of which 1627 tests turned positive (positivity rate 13.1%).¹³⁵

Of the returnees to Afghanistan, the most commonly reported health conditions among returnees included respiratory tract infections (RTIs), acute watery diarrhoea (AWD), suspected COVID-19, and scabies.¹³⁶ WASH needs, particularly lack of clean water, are one of the largest drivers of waterborne diseases. Multiple districts in the Northern, Northeastern and Southern regions are exhibiting considerable WASH needs due to high drought stress, limited access to safe drinking water, low sanitation coverage, reported acute malnutrition, acute watery diarrhoea (AWD) outbreaks, and service gaps.¹³⁷ Economic barriers leave only 20% of households reporting sufficient water, while one-fourth use unsafe water, and one-third lack soap. Rural areas exhibit higher usage of unimproved latrines (38%) and open defecation (9%).¹³⁸

Measles

A total of 2095 new measles cases with 10 associated deaths (CFR 0.5%) were reported, reflecting a 1.5% decrease compared to 2,126 cases and 11 deaths reported in November. Comparatively, there isn't significant change in the case count reported in the months of November and December.¹³⁹

Measles outbreaks can result in epidemics with a high case fatality rate, especially among young, malnourished children.¹⁴⁰ Measles is endemic in Afghanistan, with almost all provinces reporting suspected cases every year.¹⁴¹ However, limited resources and capacity within the public health system, along with hidden costs for private care and medicine, pose additional barriers to healthcare access.¹⁴²

Malaria

Each summer, heavy rains and rising temperatures create ideal breeding conditions for mosquitoes. From June to November, malaria threatens more than three-quarters of Afghans living in high-risk eastern and south-eastern provinces. Climate change has intensified the problem, with hotter summers and heavier rainfall expanding mosquito habitats.¹⁴³

After declining between 2018 and 2021, malaria cases began increasing again in 2022, peaking in 2024 and remaining high through 2025.¹⁴⁴ Nangarhar, Laghman, Kunar and Nuristan are among the most affected provinces where nearly every household faces malaria during the peak season. Most cases are caused by *Plasmodium vivax*, a parasite that can remain in the body and cause malaria to return weeks or months later.¹⁴⁵

The highest cumulative incidence of malaria per 10 000 population was reported from Nuristan (192.5), followed by Kunar (157.6), Laghman (152.4), and Nangarhar (77.7) since the start of 2025. Afghanistan has the world's third-highest malaria burden.¹⁴⁶

Acute Respiratory Infections (ARI)

In December, the surveillance system recorded 1833 02 cases of ARI pneumonia and 352 deaths (CFR 0.2%) indicating a 24.6% increase compared to the 147 138 cases and 248 deaths reported in November.¹⁴⁷

During December 2025, 131 confirmed COVID-19 cases were reported, with no associated deaths compared to 206 cases and zero death in November. This indicates a 36.4% decrease in number of confirmed cases. In December 2025, public laboratories tested 2,721 samples from suspected cases, with a positivity rate of 4.8%, marking a 30.1% decrease in testing compared to 3,891 samples tested in November.¹⁴⁸

Of the returnees to Afghanistan, the most commonly reported health conditions among returnees included respiratory tract infections (RTIs), acute watery diarrhoea (AWD), suspected COVID-19, and scabies.¹⁴⁹

Maternal and Reproductive Health Conditions

Afghanistan has one of the world's highest maternal mortality rates: a woman dies in childbirth every two hours. This crisis worsens as nearly 80% of essential health centers risk closing due to funding shortages.¹⁵⁰ The maternal mortality ratio in Afghanistan has improved from 1 346 in 2000 to 620 in 2020. Maternal mortality in Afghanistan is higher than its regional average.¹⁵¹

Although present conditions are improving, and many more children are living past infancy, in 2018, 4 out of 10 Afghan children died before their first birthday. While this is a significant drop since 1990, far too many families are unnecessarily losing their children, especially during the neonatal period. Most of these deaths can be prevented with timely and adequate care, and treatment, as well as healthy behaviours.¹⁵²

Adolescents (ages 10-19), who make up 40% of the population in Afghanistan, face tremendous challenges in meeting their sexual reproductive health needs. Afghanistan ranks 169 on the Gender Inequality Index (GII) - among the least favourable scores, reflecting high levels of inequality in reproductive health, women's empowerment, and economic activity.¹⁵³ Adolescent pregnancy rate is concerning with 16.3% of women aged 20-24 years had a live birth by age 18. Pregnancy complications and unsafe abortions were responsible for 64% of female deaths among 15-19-year-olds and 70% among 20-24-year-olds.¹⁵⁴

Four in every 10 women are undernourished and too often overlooked in the response.¹⁵⁵ Maternal and child health needs, coupled with malnutrition, contribute significantly to high maternal and under-5 mortality rates.¹⁵⁶ Good maternal nutrition is crucial for maternal health and the survival of newborns in Afghanistan, where many women start pregnancy undernourished. Poor maternal nutrition not only increases the risk of maternal mortality but also contributes to low birthweight, stunted growth, and poor developmental outcomes for children.¹⁵⁷

Access to sexual and reproductive health services, always a sensitive issue in Afghanistan, is severely constrained, undermining women's autonomy and health. While modern contraceptive methods are technically available, supply shortages, closure of family planning services, and inconsistent funding have drastically reduced availability. Health workers report being warned not to provide family planning information or services.¹⁵⁸

Estimates suggest less than half of women needing family planning have access to modern contraception. Family planning counselling is limited; unmarried women have almost no access to these services. Evidence from Afghanistan shows that education and household income are correlated with increased contraceptive use, illuminating how restrictions on women's education and work further reduce reproductive autonomy.¹⁵⁹

Women and girls face major challenges maintaining menstrual health and hygiene. Poverty limits access to menstrual products, leading many to rely on unsuitable materials, increasing the risk of infection.¹⁶⁰ LGBT+ persons report heightened risks of discriminatory treatment or being reported to the authorities, leaving them effectively unable to access safe and timely care.¹⁶¹

Tuberculosis (TB)

Tuberculosis (TB) continues to be a major public health challenge in Afghanistan. Medicines and diagnostics are made available free of charge in the country.¹⁶² In 2021, the estimated TB incidence in Afghanistan was 76 000, and an estimated 12 000 people died. Afghanistan reported 50 324 case notifications.¹⁶³

Human immunodeficiency virus (HIV)

According to the latest UNAIDS estimates (2023 data, published in the 2024 Global AIDS Report), in Afghanistan, 1700 people were newly infected with HIV.¹⁶⁴ Afghanistan is experiencing a low and concentrated HIV epidemic and HIV is a public health concern among the key affected and vulnerable populations.¹⁶⁵ The drivers of the epidemic, being verified through a consultation process and research, are generally understood to include injecting drug use, partially intersecting with multiple and concurrent sexual

partnerships, gender inequalities and violence, and stigma and discrimination. Determinants of vulnerability include high level of tuberculosis and sexually transmitted infections; drug cultivation, trade and use; low literacy level and poverty; poor HIV-related knowledge; and limited access to sexual and reproductive education.¹⁶⁶

Noncommunicable Diseases (NCD)

Access to specialist care for chronic and long-term illnesses in Afghanistan remains severely limited, driven by economic barriers and shortages of trained medical professionals, specialized facilities, and equipment. Many people cannot access care for conditions such as diabetes, cardiovascular disease, renal failure, or for rehabilitation, leaving illnesses unmanaged and increasing the risk of preventable complications and deaths. People with disabilities are disproportionately affected.¹⁶⁷

Almost 50% of all deaths in Afghanistan are caused by NCDs, and this proportion is projected to rise by 2030.¹⁶⁸ There is a double burden of communicable and non-communicable illnesses in Afghanistan, made worse by the humanitarian catastrophe that has been triggered by the country's political instability and armed conflict during the last 40 years.¹⁶⁹ The health situation has been deteriorating, particularly for women, due to widespread vulnerability, which includes extreme poverty, food insecurity, lack of access to safe drinking water and sanitation services, and natural catastrophes such as drought, flooding, and earthquakes.¹⁷⁰

A total of 56.6% of NCDs contribute to disability-adjusted life years (DALYs), and the probability of premature mortality from targeted NCDs is 30% in Afghanistan. Of this, 23.6% of the DALY burden is attributed to cardiovascular diseases. The subsequent NCDs with high disability adjusted life years (DALY) burdens are cancers (8.9%), chronic respiratory diseases (5.2%), digestive diseases (5.1%), and diabetes (4.3%).¹⁷¹

NCD services are mostly only available at the tertiary-care level and through the private sector, which makes accessing the services challenging for patients.¹⁷² A national assessment on the provision and use of essential health services in 2022 showed that NCDs were the most disrupted services and an unmet need of the Afghan population during the COVID-19 pandemic. This study showed that people need diagnostic tests and medication for the treatment of chronic diseases.¹⁷³

Afghanistan is in an epidemiologic transition stage, and the burden of cancer is expected to rise due to population growth and aging, as well as a lack of adequate strategies to prevent, diagnose, and treat diseases, especially non-communicable diseases, such as cancers. Analysis of the top five cancers, including breast, stomach, lung, cervix uteri, and colorectum, highlights the urgent need for improved healthcare infrastructure and comprehensive research in this context. Afghanistan faces significant challenges in terms of limited data availability, inadequate screening and prevention strategies, and lack of accessible and affordable cancer treatment options.¹⁷⁴ Afghanistan's inadequate cancer care infrastructure is a major issue due to a lack of data, skilled human resources, and policies and plans.¹⁷⁵

Mental Health Conditions (including substance abuse)

Devastated by decades of war, instability and poverty, many Afghans suffer from mental health and psychosocial problems.¹⁷⁶ In 2022, it was estimated 4 460 000 children and adults need mental health and psychosocial support in Afghanistan, but only 1 308 661 people were able to access services and treatment.¹⁷⁷

Afghan beliefs about mental health are influenced by collectivism, prioritizing family and community well-being over individual needs.¹⁷⁸ Mental health issues are often attributed to social or familial disharmony, which may affect perceptions of family honor. Religious beliefs play a central role, with many attributing mental illnesses to supernatural forces like jinn (spirits), the evil eye, or divine punishment. Furthermore, decades of war have normalized trauma and impacted their resilience and endurance.¹⁷⁹

Studies have found that mental health problems and psychological distress show higher risks for women, ethnic minorities, people with disabilities and youth.¹⁸⁰ Issues of suicidality and drug use are emerging

problems that are understudied. Afghans coping strategies are largely embedded in one's faith and family.¹⁸¹

Current restrictions on women's rights and freedoms have triggered a severe mental health crisis, particularly among young women. Many have seen their education, work, and personal aspirations demolished, contributing to profound stress, anxiety, depression, and suicidal ideation. Current policies also eliminate key coping mechanisms, including social interaction, outdoor activities, education and artistic expression.¹⁸²

A survey by UNODC (2024) found that around one million Afghans (age 15-64) suffer from drug addiction. At 8% of the population, this rate is twice the global average.¹⁸³ Among illicit drugs, opioids are the most harmful, causing the highest burden of morbidity and mortality attributable to drug use disorders. Between 2016–2019, over 70% of disability adjusted life years (DALYs) attributable to drug use disorders were due to opioids alone. The high prevalence of illicit opioid use in a nation with one of the world's worst public health and socioeconomic indicators, and punitive laws, leads to devastating health and social outcomes for people who use drugs in general.¹⁸⁴

Despite significant need, healthcare facilities attending to mental health issues are scarce. Currently, psychosocial counsellors provide services in most comprehensive health centres. The lack of trained psychiatrists, psychiatric nurses, psychologists and social workers presents a serious challenge for mental healthcare service delivery. Nationwide, only 320 hospital beds in the public and private sector are available for people suffering from mental health problems.¹⁸⁵ In 2025, WHO reported that most of Afghanistan's 34 provincial hospitals still lack specialized mental health services.¹⁸⁶

Substance abuse is treated primarily as a criminal offense rather than a public health issue, and drug users can face corporal punishment, detention, and forced treatment. Most drug treatment centres cater to men, with far fewer facilities for women, significantly limiting their access to care. Funding cuts since 2021 have sharply reduced service availability: by 2023 approximately 44% of drug treatment centres had closed, while only 10% remained operational, many on severely reduced budgets.¹⁸⁷

Crimean-Congo Haemorrhagic fever (CCHF)

A total of 37 new CCHF cases with one associated death (CFR 2.7%) were reported in December 2025, reflecting a 21.3% decrease compared to November. There is an observed reduction of CFR which stood at 8.5% for the month of November.¹⁸⁸ The prevalence of CCHF has been increasing in this region. These concerns are compounded because there is no vaccine or therapeutic for CCHF and Afghanistan lacks adequate public health infrastructure in preventing, detecting, and containing cases.¹⁸⁹

Dengue Fever

A total of 340 suspected dengue cases were reported in December reflecting an 85.6% decrease compared to November where 2,357 suspected cases with three associated deaths were recorded. Confirmed Malaria: During the reporting period, a total of 1,228 confirmed malaria cases were reported compared to 4,804 cases in November, marking a 74.4% decrease from the previous month. No malaria associated deaths have been reported since the beginning of 2025.¹⁹⁰

Dengue fever is endemic in Afghanistan and was first detected in 2019. In 2022 and 2023, it spread along seven border provinces in the country's eastern and south-eastern regions, threatening approximately five million people living in high-risk areas due to rapid population movements.¹⁹¹

Poliomyelitis

Afghanistan is affected by ongoing endemic wild poliovirus transmission and remain one of the two endemic countries globally. Three new WPV-1 positive cases in 2025 from Afghanistan reported this week. The new WPV1-positive cases were all from Paktika province (Bermel district) with onset dates between 6th and 10th October 2025. In total, 47 WPV1-positive cases have been confirmed in 2025 to date (16 from Afghanistan and 31 from Pakistan in 2025).¹⁹²

Afghanistan is one of the last two countries where polio still threatens children's lives. Progress is being made, with cases of wild poliovirus falling from 25 in 2024 to ten as of December 2025. But as long as the virus continues to circulate in high-risk areas, every missed vaccination leaves children vulnerable and puts hard-won gains at risk.¹⁹³ A nationwide vaccination campaign was held in May 2025. A total of 12.1 million children under 5 years of age were vaccinated for bOPV.¹⁹⁴

Diphtheria

In Afghanistan, there is a low coverage of EPI (extended program for Immunization). According to MICS report 2022-2023, the 3rd dose of DTP vaccination coverages was 51.3% among children between 12-23 months and 41.6% among children between 24-35 months. This resulted in many VBD outbreaks including Diphtheria outbreaks. This disease can affect children less than five and spread vastly within communities when children don't have enough protection by vaccination.

Skin Infections

Anthroponotic cutaneous leishmaniasis is a major public health problem in Afghanistan. Kabul is currently the largest focus of anthroponotic cutaneous leishmaniasis worldwide. In Afghanistan, 10 out of 34 provinces are badly affected.¹⁹⁵ The rise in scabies cases is a result of a complex interplay of factors, including disruptions in healthcare services, economic hardships, and restricted access due to gender-related policies. The movement of populations and close human-to-human contact also contribute to the spread of the disease.¹⁹⁶ Of the returnees to Afghanistan, the most commonly reported health conditions among returnees included respiratory tract infections (RTIs), acute watery diarrhoea (AWD), suspected COVID-19, and scabies.¹⁹⁷

Mpox

To date there are no cases reported in Afghanistan.

Meningitis

Acute bacterial meningitis (ABM) is an important cause of morbidity and mortality in children but there is little published on ABM in Afghanistan.¹⁹⁸ There is widespread childhood malnutrition and approximately 50% of children have anaemia and vitamin A deficiency. Immunization coverage against routine childhood illnesses is very low with substantial differences between cities and rural areas.¹⁹⁹

DETERMINANTS OF HEALTH

Gender Inequality

Shared with the courts for implementation in early January 2026, Decree No. 12 formally removes equality between men and women before the law. Under the decree, a husband is only criminally liable for violence within marriage if he causes severe and visible physical injuries. Other forms of violence – including psychological and sexual violence – are not prohibited. Under Decree No. 12, and when coupled with existing decrees, women face serious obstacles when seeking justice. They must prove abuse before a male judge, while fully covered, and while accompanied by a male guardian – who may be the perpetrator of the violence. The decree allows women, or their relatives, to be jailed if they go often to a relative's home without their husband's permission. Acts deemed 'immoral' or 'corrupt' are defined as crimes, punishable by the harshest penalties, including death.²⁰⁰

Protection Risks

Women and girls are being subjected to an institutionalized system of gender-based discrimination, oppression, and domination that permeates all areas of life, restricting their rights to education, work, freedom of movement, health, access to justice, and to freedoms of expression, association, assembly, and participation in public life.²⁰¹

Afghan women face physical and sexual violence from intimate partners at rates nearly three times higher than the global average; 34.7% reported being subject to such violence in the preceding 12 months, compared to 13% globally.²⁰² Practices such as honour killings, forced and child marriages, and the exchange of women and girls in dispute resolutions (baad) exacerbate gender-based violence. This severely impacts their abilities to freely make decisions and live autonomously, affecting all dimensions of gender equality. A lack of legal protection and support systems and discriminatory policies make women's and girls' vulnerability to gender-based violence and its consequences even worse.²⁰³

Survivors of gender-based violence in Afghanistan face profound barriers to accessing healthcare. Health workers, often the first point of contact, struggle to provide support.²⁰⁴ Specialist GBV units, referral networks and specialized services – including trauma-informed care, dedicated care spaces, HIV/STI testing and treatment, safe houses, and legal aid – have largely been closed or suspended. Chronic gaps in mental health and psychosocial support compound trauma.²⁰⁵

An estimated 1.4 million teenage girls are out of school due to the ban on secondary education, depriving them of their right to learn.²⁰⁶ Since the ban on female secondary school attendance was imposed, only 3% of girls attend secondary school, while among boys aged 13-18, only 44% are receiving a secondary education.²⁰⁷ Additionally, limited access to skills development and employment opportunities leaves young people vulnerable to child labour and economic exploitation, and often compelled to engage in hazardous work. The rates of child labour and marriage remain high at approximately 19% and 39%, respectively.²⁰⁸

At least 6.4 million Afghans are at risk of unexploded ordnance, with children accounting for 80% of blast fatalities and injuries.²⁰⁹ Unexploded ordnance continued to cause harm to civilians, mostly children. During the first quarter of 2025, a total of 16 civilians were killed (six men, two girls and eight boys) and 35 were wounded (3 men, 1 woman, 9 girls and 22 boys).²¹⁰ Afghanistan remains one of the most landmine contaminated countries in the world - surpassed only by Ukraine. An area larger than the city of San Francisco is thought to be littered with unexploded ordnance.²¹¹ The report shows that explosives contamination impacts approximately 20% of the population, including 100 000s of Afghan refugees forcibly returned from Pakistan and Iran in recent months.²¹² The economic cost of explosives accidents is staggering, with each fatality representing an estimated lifetime loss approximately equivalent to \$37 625 in 2025. A disability results in a loss of around \$29 101.²¹³

Recent Climatic Events

From 2-4 January 2026, western and south-western Afghanistan has been affected by heavy rainfall and consequent flash floods, resulting in fatalities and damage. As of 4 January, there were reports 17 people killed, 11 people injured, and a total of 14 700 affected. There has been extensive damage to homes, with 256 houses completely destroyed and 385 partially damaged, and agricultural land as well as perished livestock.²¹⁴

Since 22 January, heavy snowfall combined with rain has been sweeping across Afghanistan, causing fatalities and extensive damage. As of 23 January, media reports indicate that 61 people have been killed and more than 100 injured nationwide; numerous roads are closed and remote communities have been cut off. A total of 458 homes have been partially or completely destroyed in 15 of the country's 34 provinces, and hundreds of livestock have perished. For 26–27 January, additional precipitation is forecast for the whole country, with particularly heavy rain or snow expected in the southeast.²¹⁵

Since end of January 2025 the province of Zabul in south-eastern Afghanistan has been affected by continued severe winter weather, causing extensive damage. A needs assessment identified close to 1 200 individuals in urgent need of humanitarian assistance.²¹⁶

Between 5 and 10 May 2025, severe weather conditions—including heavy rain, windstorms, thunderstorms, and flash floods—resulted in the loss of seven lives and affected 183 families across the eastern and southeastern regions of Afghanistan. In the eastern region, intense rain and windstorms killed two people, injured 32 others and affected 183 families across Kunar, Laghman and Nangarhar provinces. Structural damage to homes and public infrastructures was also reported, along with significant crop losses. In the southeastern province of Khost, flash floods and thunderstorms led to five deaths, including two children

and injured one person. The floods also caused livestock losses and damaged wheat crops across 300 jeribs of farmland.²¹⁷

More broadly, a February 2026 risk assessment by IOM found that 19% of Afghanistan's population lives in high-risk communities, indicating a continued rise in overall climate vulnerability despite a slight reduction in the number of districts classified as very high risk. Provinces with the highest shares of populations living in high-risk communities include Wardak, Nimroz, Daykundi, Bamyan, and Zabul, with particularly severe risk concentrations observed in districts such as Saghar (Ghor), Saydabad (Wardak), and Tarnak Wa Jaldak (Zabul).²¹⁸

Education

On 20 March 2025, the academic year commenced, marking the fourth consecutive school year in which women and girls were excluded from education beyond grade six. The de facto authorities have not made any announcements on the reopening of education to girls and women.²¹⁹ The ban on girls' education beyond primary levels has created an educational void, severely limiting future employment opportunities and perpetuating cycles of poverty. Despite community recognition of education as a critical need, 43% of school-aged girls are enrolled, and virtually no girls aged 13–17 attend secondary school. This educational exclusion not only diminishes individual potential but also undermines the country's long-term socioeconomic development.²²⁰ On 2 December 2024, the Ministry of Higher Education announced that all public and private medical institutes, including nursing and midwifery classes, would be closed to Afghan women.²²¹

Water, Sanitation and Hygiene (WASH)

The scarcity of water, both in rural and urban areas, has intensified due to recurring droughts, escalating barriers for households from 48% in 2021 to 67% in 2023, with the likelihood of further increases without improved services.²²² Monthly household water expenditures surged from 185 AFN in 2021 to 317 AFN in 2023, indicative of the growing crisis.²²³ Inequitable access to WASH services has elevated protection concerns, with 64% of females encountering barriers and exposure to GBV during water collection. WASH needs are anticipated to grow in urban, drought-affected, and return areas. Economic barriers leave only 20% of households reporting sufficient water, while one-fourth use unsafe water, and one-third lack soap. Rural areas exhibit higher usage of unimproved latrines (38%) and open defecation (9%).²²⁴

Health Systems Status and Local Health System Distributions

Pre-crisis health system status

The health sector in Afghanistan is hampered by multiple chronic challenges undermining its performance and compromising population health outcomes. Starting in 2001, Afghanistan embarked on reforming its health system which resulted in introducing a Basic Package of Health Services (BPHS) in 2004 and an Essential Package of Hospital Services (EPHS) in 2005.²²⁵

Since then, BPHS and EPHS constituted the backbone of the health sector in Afghanistan, with services being primarily contracted out to international and national/local non-governmental organisations (INGOs and N/LNGOs, respectively), using different payment methods, and funded via a pooled fund from donors.

Following the political turnover of August 2021, much of the development funding, including for health, was paused, limiting the provision of basic services. Fortunately, a collapse of the BPHS/EPHS system was averted by quickly channelling donors' funding through United Nations (UN) agencies.

In crisis health system status

Functionality

Afghanistan faces long-standing challenges in the availability of health facilities, goods and services. This includes underinvestment in infrastructure, shortages of trained health workers. Many facilities have closed, or else operate at a reduced level.²²⁶ During the previous two decades, the Afghan government had

depended on international development support from donors to fund essential services like primary health care. The previous government's own contribution to the public primary care system was negligible, leaving it vulnerable to collapse once aid was withdrawn. Donor development aid for Afghanistan's public health system was approximately six times the government's own expenditure on health.²²⁷

Healthcare Workers

Health workers also report experiencing high levels of stress and burnout. Decades of conflict in Afghanistan had already caused widespread mental health challenges and trauma, including PTSD, depression, and anxiety, often with little access to support or care.²²⁸ Health service providers also report staff retention is a critical challenge, as restrictive working conditions, surveillance, and uncertainty drive burnout and attrition among women staff. Health workers also described compulsory religious orientation sessions, including questioning or testing on Islamic knowledge, with threats of dismissal for those deemed to lack the requisite understanding.²²⁹

Afghanistan continues to suffer from a critical shortage of health workforce. Data from 2023 shows a density of 10.3 doctors, nurses, and midwives, per 10000 population across all sectors with imbalanced distribution.²³⁰ Lack of funding for the health care sector meant that health facilities faced difficulties in paying health workers; lack of pay coupled with continued threats, arrests, and intimidation drove health workers to leave the profession or relocate.²³¹

There is significantly less females than males in the health workforce.²³² Increasingly restrictive laws directed at women and girls also had a negative impact on Afghanistan's health care system and disproportionately affected women's and girls' access to health care. Female health workers faced many obstacles while attempting to carry out their work, including harsh interrogations at checkpoints about their dress, job, or lack of a mahram.²³³

On 2 December 2024, the Ministry of Higher Education announced that all public and private medical institutes, including nursing and midwifery classes, would be closed to Afghan women, a consequential move that will have a deleterious impact not only on women's access to life-saving health services now and in the longer-term but for all of Afghan society – both women and men alike – for generations to come.²³⁴

There is already a critical shortage of women health workers: a recent analysis estimates that women make up just 27% of nonspecialized physicians, 18% of specialized physicians, and 29% of nurses. Today, only a fraction of Afghan women – estimated at 4.1 million out of approximately 15 million in 2024 – have reliable

Health system status & local health system disruptions



ACCESS TO HEALTHCARE

Around 33% of the population lives in underserved areas.²³⁵



DISRUPTION TO SUPPLY CHAIN

Medicines and medical supply shortages remain **critical**.²³⁶



DAMAGE TO HEALTH FACILITIES

Due to the escalation in border conflict, **the emergency hospital at the Turkham border post has been damaged**.²³⁷



ATTACKS AGAINST HEALTH

Limited information available

access to healthcare. By curtailing access to medical, nursing, midwifery, and allied health education, the de facto authorities have effectively dismantled the pipeline of future health professionals. Existing women health workers are retiring, emigrating, or being forced out of practice, leaving entire communities – particularly in rural and underserved areas – without trained personnel able to provide safe and acceptable care.²³⁸

Access

Afghanistan's mountainous terrain, weak transport infrastructure, and dispersed rural settlements seriously constrain access to health services, a situation compounded by high transport costs and seasonal weather. Around 33% of the population lives in underserved areas.²³⁹

Affordability is another critical factor. Although public health is free in principle, Afghanistan's health system relies heavily on out-of-pocket expenditure by households.²⁴⁰ Under the Islamic Republic, private household spending accounted for approximately 75% of total health expenditure, a figure estimated to have risen. Access to care is heavily contingent on household income, a challenge intensified by the current economic downturn, forcing many families to delay treatment, rely on informal or traditional providers, or forgo care altogether. Women and girls are disproportionately impacted.²⁴¹ Patients who can afford to, seek private treatment or travel overseas, if they can obtain visas.²⁴²

Health outcomes in Afghanistan have long been shaped by profound structural disadvantage, including decades of conflict, poverty, limited infrastructure, chronic underinvestment, corruption, and aid dependence.²⁴³ Physical access to health facilities often depends on women having a mahram who is willing and able to accompany them. This is especially challenging for women-headed households, widows, internally displaced and returnee women, separated or unaccompanied women and girls, those whose mahram has a disability, and those who may not have family support, for example LGBT+ women.²⁴⁴

Displacement, returnee status, and lack of personal identity documentation can prevent those in need, often women, from registering at facilities, receiving referrals, or accessing humanitarian support. Meanwhile ethnic, religious, and linguistic minority women have reported bias or discrimination within the health system.²⁴⁵

Financing

Afghanistan's health sector has historically been heavily reliant on external financing. National budget allocations to health, whether under the former Islamic Republic or the current de facto administration, have consistently ranked well below security and other priorities. Under the Islamic Republic, approximately three-quarters of public health and confidential meeting. This reliance was institutionalized by a contracting-out model which outsourced health service delivery functions to NGOs. While this enabled rapid expansion of health services, infrastructure, and workforce capacity, it also created a system deeply dependent on international aid and highly vulnerable to political and fiscal shocks.²⁴⁶

However, significant reductions to international funding in 2025, notably by the United States, are having serious consequences. The scale and abruptness of the cuts have significantly impacted health and related services, including nutrition, water and sanitation, and food security.²⁴⁷ An estimated 445 health facilities have been forced to close, while community awareness-raising initiatives, education programs, referrals, and protection activities have also been forced to scale-back. The situation is critical. According to the 2026 Humanitarian Needs and Response Plan, some 21.9 million people in Afghanistan require humanitarian assistance, 14.4 million of them in health.²⁴⁸

Medical Supply Chains

Medicines and medical supply shortages remain critical. Domestic pharmaceutical production is minimal, leaving the health system dependent on imports; cross-border disruptions continue to affect supply chains and availability. Health workers report high costs, increased use of poor-quality or expired medicines, and critical gaps in essential medication.²⁴⁹

Surveillance Systems

Over the past one and half decades, WHO has been working very closely with the MoPH to enhance surveillance activities, with focus on the early warning and response function. NDSR (National Disease Surveillance and response) system is built on indicator and event-based surveillance, which reports a total of 17 priority infectious diseases from 613 sentinel sites covering 99.0% of the country districts, the system also deployed a total of 105 surveillance support teams (SSTs) in 34 provinces (2025) (a modified form of classical RRTs with two members in each team consisting of one epi and another lab focal point). NDSR system with financial and technical support from WHO working smoothly in the last 3 years with notable improvement in the quality and timeliness of reports, outbreak investigation, and response activities

Humanitarian Health Response

Health Needs

An estimated 14.4 million people are expected to need health assistance in 2026, compared with 14.3 million in 2025, reflecting rising needs amid persistent vulnerabilities. The return of Afghans from the Islamic Republic of Pakistan and the Islamic Republic of Iran has placed additional pressure on the fragile health system and is overwhelming health facilities in border reception areas.²⁵⁰

Health Response

Reduced humanitarian funding in 2025 led to the closure of more than 422 health facilities, limiting access to essential health services for an estimated 3 million Afghans. The impact has been particularly severe for women and girls, who already face significant barriers to accessing health care. Movement restrictions, the limited availability of female health workers and restrictive social and institutional norms have further constrained the ability of women and girls to access timely and appropriate health care, deepening gender inequities in health outcomes and increasing the risk of preventable health complications and maternal deaths.²⁵¹

In December 2025, 49 Health Cluster partners provided humanitarian health services to 481 750 people. These services were delivered through 891 health facilities in 316 districts, covering all 34 provinces of Afghanistan. As of December 20, 2025, a total of 445 health facilities have been suspended or closed by

humanitarian partners due to the funding constraints. This disruption is expected to affect approximately 3.08 million people across 30 out of 34 provinces.²⁵²

WHO Response

WHO maintains a strategic health network across Afghanistan, providing essential health care through 128 primary healthcare facilities in 23 provinces. This network is complemented by specialized services, including two Emergency Trauma Centers (Spinboldak and Torkham), two national specialized hospitals (for infectious diseases and mental health), and five inpatient mental health wards in eight provinces. Furthermore, substance use treatment was provided in 12 Drug Treatment Centers (DATC) and five Opioid Agonist Maintenance Treatment (OAMT) centers across 13 provinces.²⁵³

The response to the health emergency in the Eastern region remains active, with 23 facilities supported by nine partners delivering essential health services including primary care, physical rehabilitation, and mental health and psychosocial support services to the affected communities.²⁵⁴

More details of WHO's Health Emergency Appeal 2026 are [available here](#)

Information Gaps / Recommended Information Sources		
	Gap	Recommended tools/guidance for primary data collection
Health status & threats for affected population	Mortality (disease-specific)	Census, facility-based surveillance, prospective mortality surveillance
	Child health - malnutrition data	Anthropometric surveys (e.g., SMART), desk-based nutritional risk assessment
	Health Assessment Tool at Community Level	Tool developed and finalized
Health resources & services availability	Community health workers using HeRAMS tools	HeRAMS is updated up to December 2024
Humanitarian health system performance	Information on quality of humanitarian health services provided to beneficiaries (accountability to affected populations)	Client and patient satisfaction conducted monthly

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