

Nutrition Action for Systemic Change (NASC) Technical Assistance
Facility (contracted through Framework Agreement EACDS 2 Lot 4)

Prioritising Nutritional Outcomes for Women and Children in Afghanistan

Summary Analysis and Recommendations

11 December 2025



Cover: *A Mother's Strength: Nargas and her daughter Arzo, aged 15 months in Mazar*

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Abbreviations

AMN	Acute Malnutrition
ARI	Acute Respiratory Infection
AWD	Acute Watery Diarrhoea
BPHS	Basic Package of Health Services
CHW	Community Health Worker
DfA	De-facto Authorities
EPHS	Essential Package of Hospital Services
FAO	Food and Agriculture Organization
FCDO	Foreign, Commonwealth and Development Office
FSAC	Food Security and Agriculture Cluster
FTS	Financial Tracking Service
GIHA	Gender in Humanitarian Action
HMIS	Health Management Information System
HNRP	Humanitarian Needs and Response Plan
IDP	Internally Displaced Person
IFIs	International Financial Institutions
IPC	Integrated (Food Security) Phase Classification
IPC AMN	Integrated Phase Classification - Acute Malnutrition
IYCF	Infant & Young Child Feeding
MAM	Moderate Acute Malnutrition
MDD	Minimum Dietary Diversity
MHNT	Mobile Health and Nutrition Team
MIYCN	Maternal Infant & Young Child Nutrition
MMS	Multiple Micronutrient Supplements (pregnant women)
MOPH	Ministry of Public Health
MoPVPV	The Ministry for the Propagation of Virtue and Prevention of Vice
MUAC	Mid upper arm circumference
N/NGO	National/Non-Governmental Organisation
NIS	Nutrition Information System (Online Nutrition Database in Afghanistan)
OCHA	United Nations Office for the Coordination of Humanitarian Affairs
PBW	Pregnant and breastfeeding women
PIN	People in Need
PND	Public Nutrition Directorate
RUSF	Ready-to-Use Supplementary Food
RUTF	Ready-to-Use Therapeutic Food
SAM	Severe Acute Malnutrition
SBC	Social Behaviour Change
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
WASH	Water, Sanitation and Hygiene
WIFS	Weekly Iron Folate Acid Supplementation
WFP	World Food Programme
WHO	World Health Organisation

Executive summary

Over the past four years, the extreme and repressive restrictions on the basic freedoms and rights of Afghan women and girls have permeated every aspect of their lives. What were once male-dominated social norms have been institutionalised and expanded, resulting in exclusion from all education beyond primary level, reduced availability of and access to basic health and social services, restricted mobility, loss of household income, and diminished autonomy over decisions affecting their health, diet and well-being.

Nutrition outcomes for women and children in Afghanistan are determined by social-cultural, behaviour and service-related factors across multiple sectors, specifically food, livelihoods, health, education, water and sanitation (WASH). Barriers for women and girls undermine nutrition, increasing mortality, illness, and harming mental wellbeing and development, which will slow the country's growth for years to come. The latest evidence from the IPC AMN (Nov 2025) indicates that the burden of acute malnutrition among children under 5 has increased by 7% (SAM: 9%; MAM: 6%), with malnutrition admissions for Pregnant and Lactating Women (PLW) increasing by 25% in 2025 compared with 2024.

By October 2025, only 34.0% of Afghanistan's Humanitarian Needs and Response Plan (HNRP) was funded. Continuing uncertainty and overall reductions in funding across nutrition-related sectors, most notably in health, food security and WASH, have led to reduction or cessation of critical interventions, including basic health services and those aimed at preventing and treating malnutrition. The curtailment of mobile services has particularly impacted remote and rural populations.

A predominance of humanitarian funding in the nutrition sector is skewed toward reducing mortality (treatment of wasting), with inadequate investment in reducing or preventing malnutrition. Data from the FTS and the Nutrition Cluster indicate that, as of the time of writing, less than 50% of the funds required for nutrition interventions in 2025 had been secured. Enormous uncertainty continues to dominate planning and implementation for 2026, and further significant cuts are anticipated across all nutrition-related sectors in 2027.

Key Recommendations

Tackling the root causes of poor nutrition across all sectors and treating severe wasting will cut malnutrition and save lives now and in the future. Key stakeholders, including donors, international financial institutions (IFIs), and implementing partners, should urgently work together to prevent the worst outcomes for women, girls and boys from materialising in 2026 and onwards. In this context, we recommend delivering on the following key areas:

Donors and partners should focus on **funding and delivery of evidence-based nutrition interventions** by:

- Prioritising nutrition intervention delivery with supplies, for prevention and treatment of malnutrition, including micronutrient supplementation, and management of malnutrition in pregnant and breastfeeding women, adolescent girls, infants and young children up to two years.
- Monitoring effective coverage of interventions and ensuring mitigation measures are in place to facilitate optimal, safe and dignified access for women and girls.

Donors and partners should address current significant missed opportunities to **improve nutrition through health, agriculture, livelihood and WASH interventions**, focusing on:

- Increasing integration of nutrition across related sectors, particularly:
 - **Health interventions** - specifically access to nutrition services for ante/post-natal care, immunisation, and prompt treatment of acute respiratory infections and diarrhoea, understanding seasonal impacts.

- **Food security, livelihoods and cash interventions** - with nutrition-related indicators included and monitored.
- **WASH** interventions - identifying and preventing seasonal fluctuations in diarrhoea and other communicable diseases.

Donors and partners should ensure **collaboration and coordination between Basic Human Needs (BHN) and Humanitarian programming for nutrition** to ensure continuity of care and crisis preparedness, focusing on:

- Enhancing community engagement involving all household members (including men) to improve household dietary, feeding and care practices and related resources for women and children.
- Prioritising communities and households experiencing multiple deprivations and with complex needs including returnees, families living in extreme poverty and female headed households.
- Innovative and meaningful partnerships with national NGOs/communities and private sector.

Strengthen information, monitoring and evidence generation by increasing focus on:

- Developing one effective and coherent system for the analysis, interpretation and use of all available nutrition-relevant information from related sectors and sources.
- Evidence generation on efficient and effective nutrition-relevant programming approaches in food security/agriculture, health, WASH and social protection interventions.
- Strengthening information and monitoring on women and infants to understand the sharp reported increase in maternal malnutrition and the potentially directly related rise in acute malnutrition in infants 0-6mths.

Coordination, advocacy, leadership

- Strengthen multisectoral nutrition collaboration mechanisms at national and subnational levels. This has been highlighted in the London Compact (Nov 2025) that unites donors, IFIs, UN agencies, NGOs and Afghan partners to keep food security and nutrition at the centre of strategy and funding decisions for Afghanistan. It sets out commitments on four fronts: using multi-sectoral, evidence-based, locally-led approaches; improving and harmonising data and analysis (including potential national nutrition surveys and use of AI); scaling up integrated, preventive and “nexus” interventions that link emergency response with systems strengthening; and tackling climate, agriculture, livelihoods and resilience together.
- Strengthen evidence-informed advocacy highlighting (i) service gaps and rising malnutrition to encourage appropriate programmatic decisions by national officials, (ii) specific short and long-term impact of restrictions on women, including longer-term and broader impact of exclusion of girls and women from education.
- Identify and share ‘good practice’ and ‘success stories’ in strengthened engagement with local NGOs and national institutions.
- Even with short-term funding, consider medium- and longer-term outlook in any interventions aiming for sustained impact and scalable approaches after support ends.

1 Introduction and background

In 2024 and 2025, FCDO commissioned several studies on women, girls and young children in Afghanistan. These include (i) a review of nutrition relevant information systems ([Link](#)), (ii) a light situation analysis, (iii) an examination of the relationship between restrictions on the rights of women and girls and likely impact on nutrition outcomes for women and children ([Link](#)) and (iv) a review of the impact of the funding situation in the context of overall uncertainty and in particular the sudden withdrawal of US aid funding ([Link](#)).

During 2025, FCDO initiated the Food Security and Nutrition Dialogue series, providing an opportunity for key stakeholders, including donors, IFIs and partners in Afghanistan, to discuss nutrition, food security, and livelihoods, and to explore areas where greater collaboration and programme adjustments could contribute to improved nutrition outcomes.

While this brief report considers (i) restrictions on women and girls and (ii) the impact of the unstable funding environment in more detail, recommendations reflect the broader set of inputs and earlier analysis.

2 Women and girls' restrictions - impact on nutrition

2.1 Background: gender norms, restrictions and enforcement

Afghanistan has long been shaped by deeply patriarchal gender norms, where men control key aspects of women's lives, including education, mobility, healthcare, and food access. Though cultural restrictions on women were significant before 2001, the following two decades saw some progress due to international presence and national efforts. Gains included improved female education, healthcare access, and employment, especially in urban and progressive areas.

Since 2021, increasingly repressive restrictions impacting on the most basic freedoms and human rights of women have reversed prior progress, worsening gender-based disparities, severely restricting freedom of movement, limiting access to essential social services, barring girls from education beyond 6th grade, (around ten years old), ceasing all third level education for girls and women and curtailing access to public spaces and employment. The restrictions have limited livelihood opportunities, deepened existing disparities, reduced participation in social activities and increased vulnerability to multiple risks. The restrictions have eroded women's ability to both seek and deliver healthcare and other critical interventions for women and their children and placed 'intolerable pressure'¹ on female health workers. In many rural and conservative households, women must seek permission from male 'guardians' to leave their homes and be accompanied by a mahram (male chaperone), even for life-saving health services like delivery or treatment for malnutrition². Deepening disparities mean that in many households, men and older members eat first, leaving pregnant women, breastfeeding mothers, and children last, contributing to high undernutrition rates.

While the overall security situation has improved, both the availability of and access to basic social services and adequate diets remain low, leading to layers of deprivation on the general population, worsened in the case of women and girls by the increasing severity and enforcement of regulations impacting their basic rights.

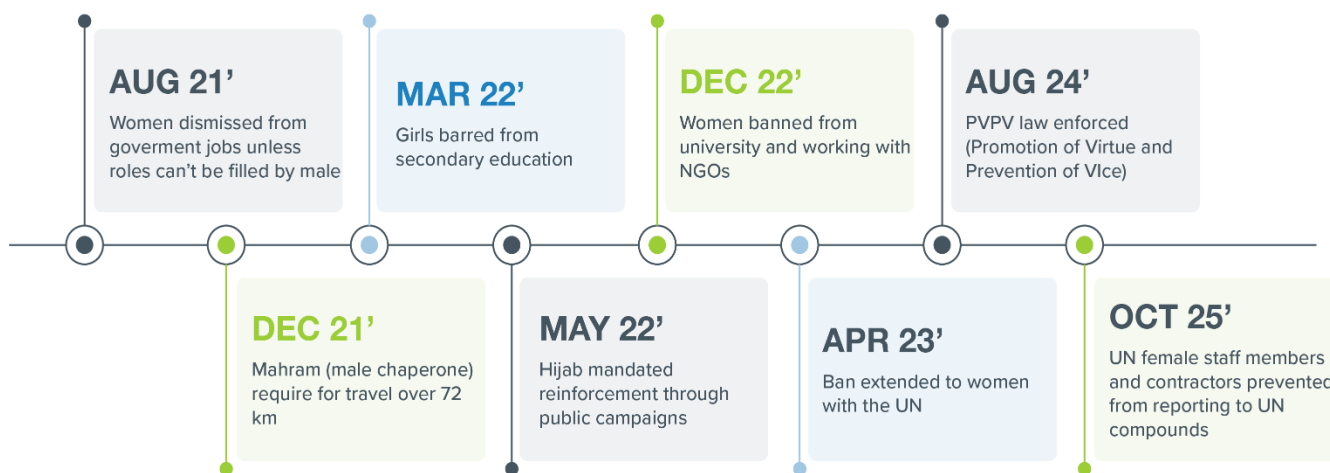
Figure 1 shows an updated timeline synthesising key restrictions. The Ministry for the Propagation of Virtue and Prevention of Vice (MoPVPV), alongside local religious councils, community informants and patrol units, ensures that the restrictions are actively and systematically enforced. Sanctions range from public shaming and threats of job loss to fines, detentions and in some cases, physical

¹ Tom Fletcher, OCHA. 2025.

² Rural Women's Access to Health In Afghanistan, Afghanistan Analysts Network, March 2025 ([Link](#))

punishment³. The interpretation and enforcement of regulations governing mahram requirements have varied significantly across regions but have become increasingly stringent over time. More recently, internet restrictions in September 2025 significantly affected the functioning of communication channels, government offices, private businesses, media outlets and online education platforms. The stated motive was moral enforcement, but the action also appears to have been aimed at tightening information control and isolating parts of society, especially women and girls, who rely heavily on online education and communication, from the outside world. The impact, if the restrictions are repeatedly applied in the future, is likely to severely limit online education as well as communications related to humanitarian and health services.

Figure 1: Key Restrictions on Women and Girls Since August 2021



2.2 Restrictions on the rights of women and girls – likely impact on nutrition

Pregnant and Breastfeeding Women (PBW) and adolescent girls face multiple, overlapping barriers to their overall wellbeing, including nutritional status. Table 1 reviews the likely impact of various restrictions and their possible influence on nutrition outcomes.

Table 1: Likely impact of various restrictions on drivers of malnutrition.

ISSUE - DRIVERS	LIKELY IMPACT ON NUTRITION
<p>Low Levels of school attendance:</p> <p>Globally, low levels of school attendance for girls are one of the strongest drivers of child marriage. In 2023, 28.7% of girls aged 18 or younger in Afghanistan were married. With the ban on girls' education after primary school, the estimated rate of child marriage will further increase by 25%, putting 37.5% of girls at risk of child marriage⁴.</p> <p>Girls banned from secondary education:</p> <p>The 2023 MICS report shows a significant education gap between girls and boys with only 32.1% of adolescent girls attending lower secondary school and</p>	<p>Early (child) marriage is associated with early pregnancies, heightened maternal and neonatal mortality (including stillbirth), morbidity risks from all causes and increased risk of low birth weight and acute malnutrition for the neonate.</p> <p>MICS 2023 secondary analysis confirms a strong correlation between a mother's education level and her child's nutrition and development outcomes, see Figure 2. Children of mothers with no formal education are significantly more likely to be stunted while those whose mothers completed secondary or higher education have better height-for-age and</p>

³ The Taliban's War on Women, Amnesty International, March 2023 ([Link](#))

⁴ Afghanistan Gender Country Profile 2024, UN Women. ([Link](#))

28.6% upper secondary, compared to 54.1% and 40.6% for boys, respectively⁵.

Since the ban on girls' education in 2021, approximately 2.2 million girls over the age of 10 have been excluded from secondary education, and a further 397,000 prevented from continuing education each year. Learning outcomes remain alarmingly low. More than 90 per cent of 10-year-olds cannot read a simple text, underscoring one of the world's most severe learning crises⁶.

Access to basic sanitation facilities:

Nationally, only 44.5% of the population has access to basic **sanitation** facilities, with a clear rural disadvantage of only 36.9% access versus urban with 66.7%.

Restrictions on employment of women:

Restrictions on employment of women across all sectors have reduced household income and women's **financial agency** with decision-making reported to have shifted almost completely towards men.

Movement limitations, lack of access to inputs, and the withdrawal of NGO support have hindered women's participation in agricultural training or cooperative marketing. While home gardening remains a potential pathway for improving dietary diversity, its impact is currently constrained by the broader environment of restricted mobility, income loss and limited access to markets.

Deterioration in women's mental health:

Key informants (KIs) and community voices describe a sharp deterioration in women's mental health. It is estimated that one in five Afghans live with a mental condition¹¹

Inaccurate information on women:

Access to reliable information: 87% of women report a reduction in female voices in media. Informal sources now fill the gap with sub-optimal and inaccurate information, often reinforcing harmful norms.

developmental scores⁷. Women with higher levels of education are more likely to adopt healthy feeding practices, such as exclusive breastfeeding and timely complementary feeding, and access available health services. They also play a more active role in child stimulation and decision-making within the household.⁸

According to UNICEF's Child Food Poverty Report Afghanistan 2025, 93% of children whose mothers have had no formal education and 86% of those whose mothers have received four or fewer antenatal care (ANC) visits live in child food poverty.⁹

MICS 2023 and Nutrition Cluster seasonality analysis show that populations with low access to safe drinking water and sanitation report higher rates of childhood illnesses such as diarrhoea with associated higher levels and seasonal spikes in acute malnutrition.

Women report having no control over how child-focused cash transfers are spent, therefore not always directed toward food or healthcare needs. A UNICEF (July 2023) report states 'in some families, cash transfer [spending] decisions are made solely by males.

Rising food prices and reduced purchasing power have driven many households toward low-cost, nutrient-poor diets, especially among urban poor and female-headed households¹⁰.

Increased anxiety, social isolation, and diminished self-worth affect nutrition-related nurturing care and development practices.

Community level maternal, infant, and young child nutrition (MIYCN) counselling and hygiene messaging has been disrupted, particularly in rural and hard-to-reach areas.¹²

⁵ MICS survey Afghanistan, UNICEF, 2022-23. ([Link](#))

⁶ Afghanistan Education Situation Report 2025, UNESCO and UNICEF. ([Link](#))

⁷ Multiple Indicator Cluster Survey (MICS) – secondary analysis, UNICEF, 2023

⁸ Afghanistan Gender Country Profile 2022 0 UN Women; REACH Gender Analysis Report 2023; MICS 2023

⁹ Child Food Poverty Report UNICEF Afghanistan 2025 ([Link](#))

¹⁰ Comparative Drought Analysis, REACH, September 2024 ([Link](#))

¹¹ WHO Afghanistan, 2025 ([Link](#))

¹² Afghanistan Acute Malnutrition Situation, IPC, June 2024 ([Link](#))

Health and nutrition workforce:

The health and nutrition workforce faces a **looming pipeline collapse** due to restrictions on girls' education and on women's participation in university, midwifery, and nursing institutes. No female health professionals have graduated in the past four years. The existing workforce is rapidly shrinking. Female staff are leaving positions due to inability to travel without a mahram, lack of accommodations for their work especially in the southern provinces and emigration.

Operational adaptations are financially unsustainable and not scalable, especially amid widespread funding cuts.

With the future availability of female health professionals now jeopardised the ability to deliver culturally and gender-sensitive services like maternal and child health, nutrition counselling and institutional deliveries is threatened, decreasing access to evidence-based interventions directly impacting infant and young child feeding practices, pregnancy and delivery related mortality and morbidity and overall child development.

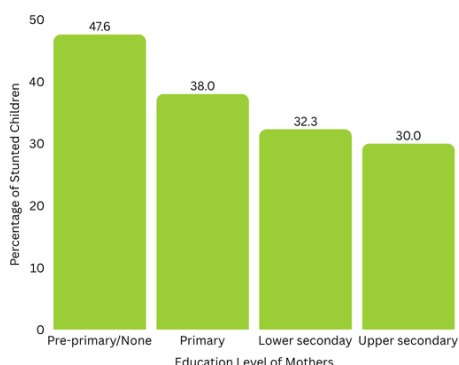


Figure 2: Nutritional status (Stunting) among children by mothers' education attainment (MICS 2023)

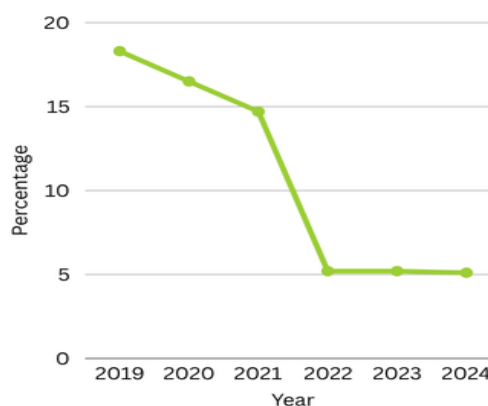


Figure 3: Labor force participation rate, female (% of female population ages 15+) (Source)

According to World Bank calculations, women's participation in the labour force declined sharply from over 16% in 2020 to 5.1% in 2024. See Figure 3. The total health staff across 4,237 health facilities is 43,080 with 24,981 male and 18,099 female.

- Gender disparities in medical specialists, with 291 females working compared to 1,136 males.
- Amongst general physicians, the male-to-female ratio is 3 to 1, and 2 to 1 for nurses.
- A total of 5,531 midwives (female) are actively working across these 4237 health facilities.
- Provinces of Jawzjan, Nuristan and Takhar have zero female medical specialists, and 23 provinces have between one and five female specialists.¹³
- A health facility staff structure is expected to include a nutrition counsellor, but the number of those currently active is not available publicly.
- Afghanistan has approx. 28,000 Community Health Workers and half of them are female.

To mitigate the impact of restrictions on the overall wellbeing of women and children, several adaptive and community-led approaches and innovative strategies have been implemented. Many of these adaptations remain fragile, localised, incur both financial and opportunity costs, and are a source of significant stress for female workers involved. While not considered system-wide solutions, the strategies and interventions include (i) Recruitment and payment of male mahram for female staff, (ii) Service relocation and clustering in static facilities, (iii) Communication of health and nutrition

¹³ WHO HeRAMS Dashboard ([Link](#))

information through grandmothers and ‘men as allies’, (iv) Use of media and digital platforms e.g. WhatsApp for basic health and nutrition messaging and (v) Collaboration with female teachers in religious schools (madrasas).

3 Evolving nutrition situation

The outlook for late 2025 and early 2026 remains bleak. According to the 2025 Integrated Phase Classification for Acute Malnutrition IPC AMN (preliminary findings), IPC projections for November 2025 to March 2026 indicate a likely worsening of acute food insecurity, with 17.4 million people expected to fall into IPC Phase 3 or worse, including 4.7 million in IPC Phase 4 across eight provinces. Acute malnutrition is also set to deteriorate, with 4.9 million PBW and children under five projected to be malnourished. In anticipation of continuing uncertainty and a likely downward funding trajectory for both Basic Human Needs (BHN) and Humanitarian programmes, partners have implemented multiple changes including:

- Rationalisation of services at health facility level towards a more woman-and-child focussed integrated service spanning BHN and Humanitarian.
- Combined coordination/monitoring of both BHN and humanitarian nutrition-specific interventions by the Nutrition Cluster.
- Implementation of alternative management protocols for both severe and moderate acute malnutrition, including the shift to UNICEF’s management of SAM and high-risk MAM and WFP’s focus on prevention of malnutrition and management of uncomplicated MAM, as per the 2023 WHO guidance on management of wasting and the 2025 Joint Action to Stop Wasting UNICEF/WFP.

In 2025, basic health and related services were significantly affected by the cessation of activities by multiple NGOs following the withdrawal of US funding. Seasonal fluctuations in food security and periodic shocks such as drought, floods, earthquakes, outbreaks of communicable diseases challenge the population’s resilience and prevent progressive improvement in nutritional status. The latest IPC AMN (Nov 2025) provided a clear 12-year trend analysis linking acute malnutrition to seasonal disease and water stresses. From this data, evidence points to two acute malnutrition seasons:

- High season (June to September) during harvest and post-harvest with high levels of malaria and acute watery diarrhoea
- Low season (October and May) during the lean season with high levels of acute respiratory infections and pneumonia.

This shows that seasons of acute food insecurity and acute malnutrition do not match in Afghanistan, as well as geographical areas with the highest food insecurity being different to those with the highest malnutrition. The post-harvest season has peaks in malnutrition, and the lean season has ‘low’ malnutrition, although heightened malnutrition persists. Access to health and nutrition services are affected in the winter season with poor care and feeding practices for children 6–23 months persisting all year round.

Since 2024, the Nutrition Cluster (leadership and members) has supported several changes which have significantly improved the availability and reliability of nutrition information, e.g. expansion of surveillance, strengthening data quality, stronger cross-sectoral analysis and integration in the IPC. Lead organisations have initiated innovative programming approaches that have the potential to increase the efficiency and effectiveness of nutrition-related interventions.

Afghanistan continues to face critical gaps in immunisation coverage, with all essential vaccines given in the first year of a child’s life falling significantly lower than the 90% target set in the Immunisation Agenda 2030. According to the WHO/UNICEF joint estimates, measles 1 vaccine coverage was 55% among children aged 12-23 months during 2024.

particularly during pregnancy and breastfeeding, (ii) rely on unimproved water sources, (iii) live in households with 5-7 members and (iv) have two or more children under the age of two. Women aged below 29 are at significantly higher risk of being malnourished.

Consistent with global evidence, the analysis showed that women's education is a powerful protective factor. *Mothers who were educated had a 40% lower risk of malnutrition.*

3.2 Under 5 Mortality

U5 mortality rates in Afghanistan have constantly declined since 2000. Based on the UN Inter-agency Group for Child Mortality Estimation, the latest estimation was conducted in 2023 and was 55.5 (42.4 – 72.7) per 1000 live births. Although there has been no more recent field data on child mortality after MICS 2022-23, the planned Afghanistan Health Survey (AHS) will include data on child and infant mortality. Efforts are also underway to develop modules for estimating mortality rates using HMIS data and phone interviews, in the absence of surveys.

While availability of U5 mortality data is a challenge, mortality risk is undoubtedly being increased by a number of factors, including multiple outbreaks of communicable diseases¹⁴, low immunisation rates, neonatal vulnerability due to low birth weight related to worsening maternal health and nutrition, as well as likely increases in the 0–6-month age group due to exceptionally high wasting levels. While acquiring accurate mortality data remains a challenge, the associated risk factors need close monitoring.

4 Nutrition-related funding – fluctuations and prioritisation

In recent years, funding for nutrition-related interventions in Afghanistan has been highly uncertain. Significant fluctuations have impacted consistency of programming such as Supplementary Feeding Programmes for vulnerable children and consistent significant deficits in critical sectors like WASH.

In 2025, Afghanistan's nutrition response was further severely impacted by major funding cuts, most significantly those of USAID whose sudden suspension led to widespread disruptions across health, nutrition, WASH, and food security sectors with reductions and cessation of NGO interventions, closure of health facilities, reductions in food related interventions (agriculture, food and cash) and an abysmally low level of planned interventions in the critical WASH sector.¹⁵ Funding of key coordination roles across multiple clusters related to nutrition including the Nutrition Cluster were initially at risk due to lack of funding, threatening inter-agency coordination and response planning.

In response to multiple complex crises, total nutrition funding peaked sharply in 2022, reaching US\$326.2 million. However, both total and U.S. funding saw a notable decline in 2023, with U.S.

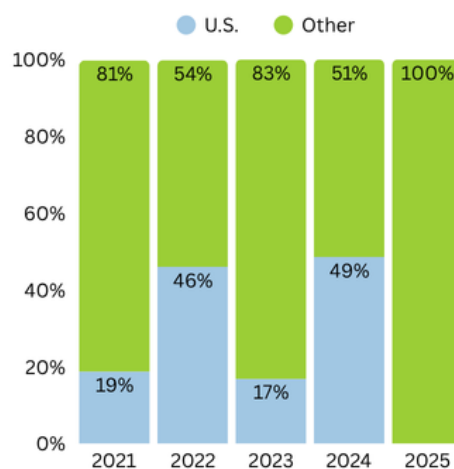


Figure 5: Proportion U.S. and non-U.S. Nutrition Funding Received by year.

¹⁴ Measles burden has increased in 2025 with approximately 85,000 suspected cases and 513 associated deaths being reported by August 2025 (Afghanistan Infectious Disease Outbreaks Situation Report, No. 33, 10-16 August. WHO.). The highest cumulative incidence of suspected measles cases per 10,000 population has been reported from Helmand (76.4), which has also been one of the three provinces with GAM rates of over 20% during quarter three of 2025, indicating the association of measles outbreaks with a reported increase in wasting.

¹⁵ The US has been the largest donor to Afghanistan since 2013, contributing 47 per cent of the total funding for the Humanitarian Needs and Response Plan (HNRP) in recent years.

support dropping to just US\$6.7 million. In 2024, a significant increase in U.S. funding (US\$49 million) was seen with the total funding for nutrition at \$100.9 million.

As of December 10, 2025, FTS reports receipt of \$75.6m for Nutrition or 25.5% of the \$296m required¹⁶. As not all partners report funding to the FTS, separate Nutrition Cluster reports indicate that \$148.1m has been received, representing 50% of funding requirements.

With an estimated 16.8 million people, out of 22.9 million people in need, targeted for humanitarian assistance in 2025,¹⁷ sectors directly related to nutrition (food security and agriculture, WASH) report under 10% of required funding by October 2025, as per UN FTS tracking. The health sector is now 22.8% funded.

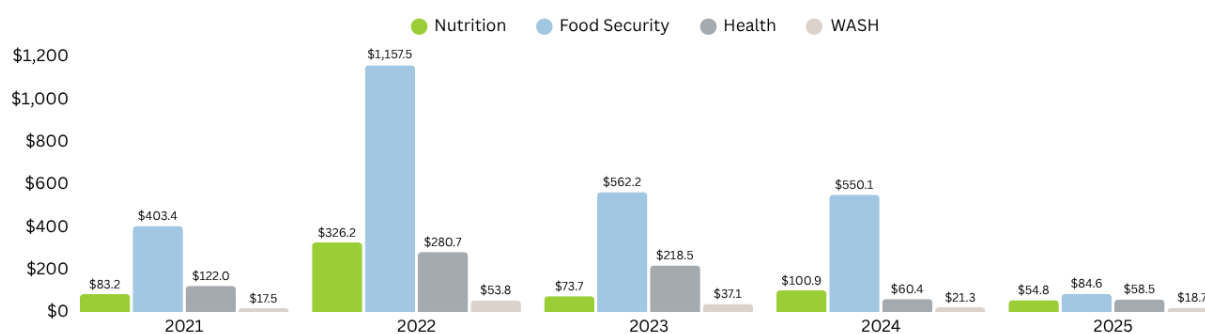


Figure 6: Paid Funding Received by Year and by Sector in Millions [FTS]

Between 2021 and 2024, funding across all key humanitarian sectors, nutrition, health, food security and WASH experienced notable fluctuations with a dramatic spike in funding across all sectors, particularly food security. In 2023, funding levels dropped significantly across the board, though food security remained the top-funded sector. By 2024, funding levels began to stabilise, showing a modest rebound in nutrition, health and WASH, but remaining below 2022 peaks. As of 10 December 2025, only USD 907 million - just 37.5% of the USD 2.4 billion required under the HNRP 2025 has been funded.¹⁸

Nutrition Cluster Costing for the 2025 Humanitarian Response Plan (HRP) showed that approximately 78% of the funding was planned for inpatient and outpatient treatment of SAM for children aged under-five, and treatment of MAM for children aged 6-59 months and women, while only 22% was designated for prevention, such as Vitamin A Supplementation & deworming, IYCF counselling & growth monitoring, and BSFP for children and women.

According to ACAPS, in 2024, Afghan NGOs received 28.6% of all funding allocated through the Country Based Pooled Funds¹⁹, a significant increase from 18.7% in 2023 and 21.6% in 2022. Afghan NGOs also receive funding through INGOs and UN agencies as implementing organisations.

¹⁶ Funding figures reflect amounts actually received by partners and not funds that were committed but not paid.

¹⁷ Humanitarian Crisis Analysis, Sida, 2025 ([Link](#))

¹⁸ Afghanistan Funding Tracking Service (FTS), OCHA – April 2025 ([Link](#))

¹⁹ ACAPS Afghanistan, February 2025 ([Link](#))

5 Trajectory- what next for women's and children's nutrition?

Malnutrition in Afghanistan is driven by (i) both chronic and acute food insecurity leading to inadequate dietary intake particularly for women, adolescent girls and young children; (ii) inadequate health, education, social and sanitation infrastructure, poor quality of services and care practices, frequent outbreaks of communicable diseases including Acute Respiratory Infections, Diarrhoea and measles, and (iii) adverse social and environmental challenges, particularly for women and girls, leading to women's and children's sub-optimal care, eating and feeding practices. See UNICEF Conceptual Framework for Nutrition in Annex 2. The situation is more broadly challenged by worsening gender-based inequalities with restrictions on women's education, work and movement, increasing poverty, limited economic opportunities, worsening human-resource capacity gaps, increasing climate-induced disasters and risks and high levels of internal displacement and returnees. Currently, young children under two years, infants and women of childbearing age most likely experience the highest burden of malnutrition. Malnutrition among infants (0-6 months) is closely related to the health, nutritional status and overall wellbeing of the mother.

If restrictions on the freedoms and rights of women persist, together with inadequate national investment and donor funding of essential interventions, Afghanistan is likely to experience a deterioration or stagnation in progress in acute and chronic malnutrition among children, maternal and newborn deaths and increased under-five mortality. Evidence from the IPC AMN analysis in November 2025 predicts a worsening of acute food insecurity, with 17.4 million people expected to fall into IPC Phase 3 or worse, including 4.7 million in IPC Phase 4 across eight provinces. Acute malnutrition is also set to deteriorate, with 3.7 million children under five suffering from acute malnutrition, and an additional one in every two children (0–59 months) is stunted, signalling chronic malnutrition and long-term impacts on growth, learning, and development. The trajectory is looking bleak with 1.2 million PBW suffering from acute malnutrition, with 2025 PBW admissions having increased by 25% compared to 2024 and predicted to further increase into early 2026. Restrictions on women's mobility, employment, and access to healthcare further limit service delivery and increase risks for children and mothers, leading to a further deterioration unless drivers are addressed.

With widening gender disparities in services access, and a shrinking health workforce, the future trajectory of nutrition outcomes for women, adolescent girls and children is likely to be seen in:

- Increase or stagnation in all forms of malnutrition due to inadequate investment in drivers e.g.
 - i. Food & agriculture sector through persistent dietary inadequacy for women and children,
 - ii. WASH sector through persistent high prevalence of communicable diseases (AWD, and
 - iii. Health sector through untreated micronutrient deficiencies, suboptimal feeding practices and delays in treating childhood illnesses.
- An increase in all forms of child malnutrition and poor development outcomes, as the proportion of children born to mothers with lower education status increases
- Increased mortality risk for children in the 6-12 months age group due to a reduction in the coverage of treatment for severe acute malnutrition, risking reversal of under-five mortality reduction trends.
- Increase in anaemia for adolescent girls due to reduced access to iron-folate supplementation and continued inadequate dietary intake.
- Increased mortality and morbidity risk for women and for infants, including increased risk of low birthweight due to:
 - continued maternal malnutrition and sub-optimal care of PBW
 - increase in teenage pregnancies,
 - reduced access of women to appropriate nutrition-relevant care and supplementation during and after pregnancy
 - reduced access to appropriate care from female midwives, doctors and nurses during pregnancy and delivery.

6 Recommendations

While drivers tend to be consistent across populations with higher levels of malnutrition, interventions to *address* drivers must be context specific. Interventions to address specific seasonal fluctuations in outbreaks, food access, dietary deficits or population movements need to be identified, incorporated in planning, and follow a pathway that ensures the most vulnerable children and women are reached.

Effective and efficient interventions include:

- Effective cover of high-impact nutrition interventions with additional focus on preventing malnutrition – these could include exclusive breastfeeding to 6 months, continued breastfeeding to 2+ years, and appropriate complementary feeding, (ii) micronutrient supplementation: including Vitamin A, Iron (especially for women/children), and Iodine (as per specific population deficiencies), (iii) treatment of malnutrition, (iv) dietary diversity, (v) health and WASH practices including deworming, prompt and adequate treatment of ARIs and AWD.
- Full integration of nutrition across sectors, particularly health, food and agriculture, social protection and WASH
- Stronger interpretation and effective use of existing data, especially around seasonality, to inform actions and monitor interventions.

And will involve:

- Mitigation measures and adequate support to ensure women, adolescent girls, infants and young children up to two years, and children access effective services and benefit from targeted evidence-based, high impact interventions.
- Greater programmatic focus on prevention of malnutrition with a commensurate increase in the proportion of funds allocated. While treatment (importantly) reduces mortality risks for severely malnourished children, prevention of malnutrition reduces mortality and morbidity risk for all stages and forms of malnutrition. It is cost-effective, reduces future treatment costs and burdens, and averts longer-term disabilities and developmental losses, with broader benefits, including substantial economic and social returns.
- Innovative rationalisation approaches to collaboration and coordination of nutrition programming between BHN and Humanitarian.
- Community engagement and participation in nutrition-relevant and context-based social and behaviour change interventions involving all household members improve outcomes for women and children.
- Support to evidence-based interventions and new partnerships to improve complementary feeding e.g. First Foods initiative.

Multisectoral interventions and collaboration will involve:

- Optimising nutrition relevant investments in food, agriculture, livelihood, health, social protection and WASH sectors (existing and new), during design and monitoring of interventions, particularly those related to diet and communicable diseases. Ensure nutrition-relevant indicators and results are included during the design and monitoring of interventions.
- Prioritisation of populations experiencing multiple deprivations and with complex, including returnees, families living in extreme poverty, female headed households, persons living with disabilities etc.

Coordination, information management and evidence generation will focus on:

- Effective and coherent system, structure and accountability for the analysis, interpretation and use of all available nutrition-relevant information from related sectors and sources.

- Focus on interpretation and effective use of existing data, using extrapolation and global evidence where relevant data is either unavailable or unreliable.
- Continued actions to strengthen data quality and flag data and sources that are unrealistic, misleading or of otherwise poor quality.
- Generate evidence on more efficient and effective integration of nutrition across sectors.
- Continuing to measure the impact of restrictions including the longer-term and broader impact of the exclusion of girls and women from education.

And more specifically:

- Further investigation into the increases seen in MAM programme admissions for PBW to examine diverse issues, including specific programming changes in either MAM programmes or ante-natal care in general, data anomalies, population influx, changes in household economy / food security that could be contributing to the increase. It will be important to monitor any concurrent increases in low birth weight (when measured), neonatal mortality (if reported), SAM or MAM in the 0–6-month age group and outbreaks of communicable diseases.
- While recording and monitoring of under-5 mortality remains challenging, monitoring of factors associated with under-5 mortality, including outbreaks of communicable diseases, especially measles, untreated severe wasting, maternal malnutrition, child marriage and related early childbearing, low-birthweight and wasting in infants, will provide a strong indication of risks and possible trajectories.
- Monitoring outbreaks of communicable diseases and their seasonal association with increases in malnutrition.

Coordination and leadership

- Support single nutrition coordination structure for BHN and humanitarian interventions
- Demonstrate leadership in senior management among development and humanitarian partners
- Strengthen *multisectoral* nutrition coordination and collaboration mechanisms at national and subnational levels
- Even with short-term funding, promote medium- and longer-term outlook nutrition interventions aiming for sustained impact and scalable approaches after support ends.

Advocacy

- Strengthen evidence-informed advocacy highlighting (i) services gaps and malnutrition risks to encourage more effective decisions by local officials, (ii) specific short and long-term impact of restrictions on women and girls.
- Identifying ‘good practice’ and ‘success stories’ in strengthened engagement with local NGOs and national institutions.

Collaboration and localisation

- National NGOs (NNGOs) are increasingly becoming involved during the design and development phase of programmes, demonstrating good practices in partnerships e.g. DAWAM and ensuring locally appropriate and context specific programmes are considered from the design phase.
- Considering the enormous nutritional needs and declining funds, Afghanistan can leverage potentially low-cost and sustainable approaches to address the widespread malnutrition across the country by optimising the role of local institutions and NNGOs. Progressive steps will include (i) facilitating participation of NNGOs, particularly those with evidence of women strongly influencing decision-making, design and implementation, or with strong (even if not

public) presence of women in management positions, (ii) identification of opportunities to test innovative, cost-effective and sustainable approaches to improving nutrition, (iii) utilising existing evidence from the National Food-based Dietary guidelines for Afghans²⁰, and initiatives such as the Future Smart Foods of Afghanistan²¹ and the Healthy Food, Happy Baby, Lively Family manual²² for promotion of local recipes and food-based approaches to improve diets of women, infants and young children, (iv) leveraging existing community-based platforms to improve household practices and behaviours related to nutrition.

- Engagement of food producers and processors, retailers and pharmaceutical companies can improve stable access to affordable, nutritious foods and supplements through investment in processing, packaging, marketing, storage, fortification, preservation etc. Public-private partnerships can support outreach and promote consumption of products through targeted communications.

7 Conclusions

Recent severe restrictions on the rights of women, impacting on movement, education, employment, livelihoods and autonomy have been particularly devastating, representing significant short and longer-term threats to the wellbeing of women and girls, and jeopardising the future wellbeing and development of children. Inadequate and unpredictable funding places an even greater importance on ensuring that interventions are based on evidence, shown to be effective in improving malnutrition and also cost-effective.

Nutritional status remains one of the best outcome indicators of overall human well-being in a population. Since the development of the UNICEF conceptual framework over three decades ago, it has been well understood that interventions across multiple sectors are required to improve nutrition. Multi-sectoral collaboration is imperative and more likely to be effective if nutrition-related indicators are integrated into programme design.

²⁰ National food-based dietary guidelines for Afghans, FAO, 2016 ([Link](#))

²¹ Future Smart Foods of Afghanistan, FAO, 2021 ([Link](#))

²² Healthy food, happy baby, lively family manual, FAO, 2008 ([Link](#))

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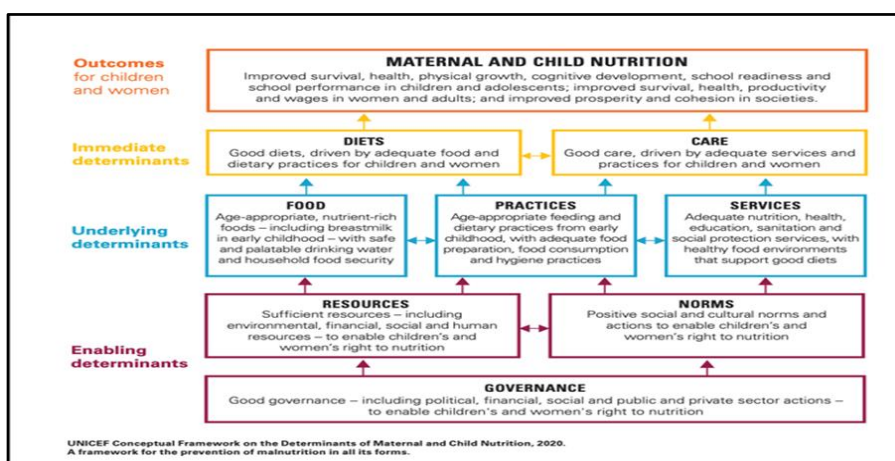
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Annex 1: Key Restrictions on Women and Girls Since August 2021

Date	Restriction	Implication
August 2021	Women dismissed from government jobs unless roles can't be filled by male ²³	Loss of income; rise in female headed household vulnerability
December 2021	<i>Mahram</i> (male chaperone) require for travel over 72 KM ²⁴ , however, in practice in some locations short distance travels are also affected – based on different interpretation of the decree by the frontline Taliban forces.	Severe limitation on mobility and independence. Sometimes <i>mahram</i> requirement also applies to shorter/local travel in more conservative areas.
March 2022	Girls barred from secondary education ²⁵	Disruption in education pipeline; institutional erasure of gender responsive policy bodies, that disrupted the pipeline of future female health professionals. Children of mothers with no education are significantly more likely to be stunted.
May 2022	Hijab mandated; reinforcement through public campaigns	Increase harassment; loss of access to services without compliance
December 2022	Women ban from university education, all higher education incl. nursing & midwifery and working with NGOs. In some areas, local & short distance travels are also affected ²⁶ .	Isolation, loss of agency and income, restricted access to aid for female beneficiaries
March 2023, documented in July 2023	<i>Mahram</i> requirement for female health workers ²⁷ .	Suspension or disruption of MHNTs; reduced outreach and community services.
April 2023	Ban extended to women with the UN, following a similar ban issued in December 2022 for NGOs ²⁸ .	Eroded operational capacity of humanitarian programming
August 2024	PVPV law enforced (Promotion of Virtue and Prevention of Vice)	Codified repression; public flogging for perceived moral crimes

Annex 2: UNICEF Conceptual Framework for Nutrition



²³ The Taliban's War on Women, Amnesty International, March 2023 ([Link](#))

²⁴ The Taliban's War on Women, Amnesty International, March 2023 ([Link](#))

²⁵ The Taliban's War on Women, Amnesty International, March 2023 ([Link](#))

²⁶ The Taliban's War on Women, Amnesty International, March 2023 ([Link](#))

²⁷ Afghanistan Nutrition Cluster – Mahram Impact Brief – July 2023

²⁸ Gender In Humanitarian Action (GIHA), UN Women, March 2025 ([Link](#))